

Care Quality Commission

Inspection Evidence Table

The Park Medical Group (1-543567243)

Inspection date: 2 and 7 December 2022

Date of data download: 05 December 2022

Overall rating: Good

When we inspected this practice in November 2021, we rated them as requires improvement overall. This was because we had concerns about medicines optimisation; the effectiveness of care and treatment for people with long term conditions; staff training and appraisals; and governance arrangements.

At this inspection we found the practice had addressed all the areas of concern and had implemented effective improvements. The practice is therefore now rated **good** overall.

Safe

Rating: Good

When we inspected this practice in November 2021, we rated them as requires improvement for providing safe services because:

- The processes for the safe handling of requests for repeat medicines and for monitoring the safety of high-risk medicines were not effective.
- The provider did not have formal processes in place to review the prescribing competence of non-medical prescribers.
- The process for receiving and acting upon patient safety and medicine alerts was not always effective and did not provide a formal audit of the actions taken by the provider.

At this inspection we found the practice had addressed all the areas of concern and had implemented effective improvements. The practice is therefore now rated **good** for providing safe services.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes ¹
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes ²
Explanation of any answers and additional evidence: ¹ In November 2021, we found there was no formal risk assessment in place as to why a DBS check was not required for some roles. At this inspection, we found the practice had addressed this and implemented a risk assessment to support where a DBS check was not required for a role. In November 2021, we reported the practice were having difficulty in encouraging the local health visiting team to attend multidisciplinary meetings. In December 2022, we found the practice had set up local meetings. However, they told us they planned further improvements with a smaller meeting dedicated to discussing safeguarding with the practice lead, the linked health visitor and midwife.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial ¹
Explanation of any answers and additional evidence: ¹ We saw evidence the practice maintained a record of clinical staff vaccination status in line with guidance and some but not all records for non-clinical staff.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: May 2022	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 11 October 2022 (Kingston Park) interim risk assessment 11 October 2022 (Fawdon) with full risk assessment planned for 9 February 2023. Actions from fire risk assessment were identified and completed.	Yes

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 24 January 2022 (Fawdon) and 17 January 2022 (Kingston Park)	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes ¹
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes

Explanation of any answers and additional evidence:

¹ Our review of patient records in relation to the clinical searches identified that care records were managed in line with current guidance.

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHS Business Service Authority - NHSBSA)	1.01	0.91	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2021 to 30/09/2022) (NHSBSA)	9.5%	7.7%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2022 to 30/09/2022) (NHSBSA)	4.37	4.79	5.28	Tending towards variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	182.0‰	212.7‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)	0.56	0.43	0.58	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	5.1‰	6.4‰	6.7‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Partial ¹
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes ²
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Yes ³
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes ⁴
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	NA
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes ⁵
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>¹ Blank prescriptions were stored securely and there were systems in place to monitor their use. However, this was not as effectively managed at the smaller site, Kingston Park. Incoming prescriptions were noted, but it was not possible to identify from audit processes when prescriptions had been handed to clinicians for use.</p>	

Medicines management	Y/N/Partial
<p>² In November 2021, we found the practice did not have formal processes in place to review the prescribing competence of non-medical prescribers. At this inspection, we found the practice had taken action to address this. They had implemented a peer and case review process as well as carried out audits of prescribing activity alongside an improved appraisal processes to ensure the competence of non-medical prescribers.</p>	
<p>³ Medicine reviews – We checked a random sample of medicine reviews conducted by the practice and found evidence of structured medicines reviews for patients on repeat medicines.</p>	
<p>⁴ High risk medicines and DMARD medicines - In our previous CQC inspection (November 2021) we found the arrangement in place to monitor high risk medicines were not safe and effective. In December 2022, we carried out remote clinical searches to check if the practice had made improvements. We found there were now appropriate arrangements in place to monitor high risk medicines and disease modifying anti-rheumatic drugs (DMARDs) medicines. The practice had identified an issue with the monitoring of Lithium, which meant the full range of blood monitoring had not been carried out. They were implementing an action plan to address this.</p>	
<p>⁵ At the last CQC inspection, we found the practice did not hold atropine (for treating patients at risk of bradycardia during coil fittings or minor surgeries) or have an appropriate risk assessment to demonstrate why it was not required as part of the emergency medicines. In December 2022, we found the practice now carried this as part of their emergency medicines.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	11
Number of events that required action:	11
Explanation of any answers and additional evidence:	
<p>In our November 2021 inspection, we found although the practice had processes in place to learn and improve when things went wrong, there were sometimes delays in considering events, which meant some improvements which could be implemented quickly were delayed.</p> <p>At this inspection, we found the practice had made improvements. They had identified opportunities in regular scheduled meetings to discuss and agree on actions following significant events, so improvements were not delayed whilst waiting for formal significant events meetings to take place.</p>	

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
Remote prescribing of combined contraceptive pill missed contraindication of patient's weight	Learning shared with team and discussion about how to tactfully discuss weight with patients. Contraceptive review template implemented which included a question about weight to support safe prescribing.
Patient responded to incorrect name when being called into an appointment.	Learning shared with team and reminded of the importance of checking identity, including date of birth, before commencing an appointment, assessment or treatment. Alerts were placed on patient records with similar sounding names and other identity information.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes ¹
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>¹ In November 2021, we found the practice did not have a formal process to log and update actions they had taken against patient safety and medicine alerts. They also did not have a process in place to check whether current prescribing took account of still relevant but historical patient safety and medicine alerts.</p> <p>In December 2022, we carried out remote clinical searches and found improvements had been made. A review of a random sample of clinical records found there were appropriate arrangements in place to respond to patient safety and medicine alerts.</p> <p>We also saw the practice now maintained a formal log of actions they had taken against patient safety and medicine alerts. However, the practice had identified further improvements to ensure a regular scheduled audit was undertaken to identify those patients who had been prescribed medicines subject to medicine safety alerts that had not been otherwise picked up, for example in the new patients checks or hospital prescribing.</p>	

Effective

Rating: Good

In November 2021, we rated the practice as requiring improvement for providing an effective service because:

- Patients' needs were not always assessed, and care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance. The arrangements for the call and recall of patients with long term conditions were not always effective and the clinical coding arrangements did not support the provider to identify and meet the needs of patients.
- The management of training and appraisal for staff did not effectively support the provider to recognise gaps and areas for improvement.

In December 2022, we found the practice had improved the way they provided care and treatment and it was now in line with current legislation, standards and evidence-based guidance. They had improved the governance of training and support available for staff. Therefore, we now rated the provider as **good** for providing effective services.

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes ¹
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes ²
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes ³
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice prioritised care for their most clinically vulnerable patients.	Yes
Explanation of any answers and additional evidence: ¹ In November 2021, we found monitoring processes for patients with long term conditions was not effective, both in terms of regular recalls and in responding to risks identified by clinicians working in	

the practice. We carried out remote clinical searches as a part of this inspection and from the sample of records we reviewed, we found:

- Appropriate arrangements in place to monitor and review patients with acute exacerbations of asthma requiring a prescribed course of oral steroids and patients with Chronic Kidney Disease Stages 4 or 5.
- There were also appropriate arrangements for monitoring patients with hypothyroidism. However, we identified there were some patients with this condition who had not picked up their prescriptions, but who had been invited to review. The practice told us this would be identified and discussed at the annual review appointment.
- There were appropriate arrangements in place to monitor patients with diabetes who had diabetic retinopathy and also a very high HbA1c result at the last reading.

The practice had improved their monitoring of long-term conditions and now had effective processes in place to recall and respond to risks, as evidenced by our remote clinical records review.

² At our inspection in November 2021, we found evidence of some missed diagnoses of both diabetes and chronic kidney disease. At our inspection in December 2022, we carried out remote clinical searches of patient records and found 1 patient with a potential missed diagnosis of diabetes and 12 patients with a missed diagnosis of chronic kidney disease. We reviewed 5 records of the patients with a potential missed diagnosis of chronic kidney disease and found none had chronic kidney disease stage 3, 4 or 5. Appropriate arrangements were in place to monitor those patients.

The practice had improved their monitoring of patients with symptoms which could indicate serious illness and followed them up in a timely and appropriate way, as evidenced by our remote clinical records review.

³ Our remote clinical searches found patients' treatment was regularly reviewed and updated.

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were provided on request to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were referred for ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	115	125	92.0%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	122	131	93.1%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	123	131	93.9%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	123	131	93.9%	Met 90% minimum

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	118	142	83.1%	Below 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

Evidence from the remote clinical searches we undertook indicated the practice were up to date with childhood immunisations. The practice had arrangements in place to follow up where children were not brought in for their immunisations, with parents or guardians contacted to encourage uptake.

The practice told us at the last CQC inspection (in November 2021) they were aware of and addressing a data quality issue in relation to immunisation data. They told us they were still working with other organisations to resolve this issue, with a manual work around in place to address this in the interim.

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)	72.7%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	74.2%	65.4%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	73.4%	68.2%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	53.3%	53.3%	55.4%	No statistical variation

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Any additional evidence or comments

In November 2021, we said the practice should continue to review and take action to improve cervical screening uptake. At this inspection we found although there had not been an improvement in the coverage of cervical screening, the practice had been working with partners to identify and address barriers to uptake.

The Primary Care Network (PCN) had carried out a survey to capture why patients did not attend for screening. This took place between 25 May and 13 June 2022. The key findings were:

- Embarrassment, anxiety and worry about the procedure being painful were some of the top reasons for not attending screenings.
- Patients wanted more and better information about the changes to testing for HPV first, rather than looking at cells and for people who do not have sex with men.
- Most of respondents said the staff carrying out the appointments put them at ease, communicated clearly with them and prioritised dignity and privacy.
- However, some of patients were unaware of the adjustments they could ask for – different speculum sizes, for instance.

As a result of this survey practice's across the PCN were rolling out new reminder letters and had produced a video which included information for patients, including statistical information about death rates and the preventability of the disease supported by effective screening.

The practice also encouraged uptake with personalised phone calls for those who did not respond to reminders.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

Examples of improvements demonstrated because of clinical audits or other improvement activity in past 2 years

The practice had carried out a number of clinical audits, data collection and quality improvement exercises to help them identify and make improvements. This included audits on cervical cancer and screening; monitoring of high-risk medicines; adherence to selected alerts published by MHRA; and, asthmatics requiring the steroid prednisolone.

Example of improvements were:

- An audit of patients prescribed thyroxine to check they had levels checked within the last 18 months. The practice had carried out this audit in 2019, 2020 and again in 2022. It was not carried out during the COVID-19 pandemic because of changes to the way long term conditions were monitored through this period. This found patients who had not had blood testing within 18 months had reduced from 35 (6.4%) in 2019, to 33 (6.2%) in 2020, to 15 (2.8%) in 2022. Of the 15 patients identified in the most recent audit, 1 had blood test results available, but these had not been downloaded to the clinical system, 5 had appointments for blood tests within the next 2

weeks. Of the remaining 9 patients, the practice made arrangement to follow up and invite again for review. They limited prescription supply to encourage patients to attend for monitoring and review.

- An audit of disease modifying anti-rheumatic drugs (DMARDs) to check the recommended monitoring was being carried out and recorded in medical records appropriately, carried out in February and November 2022. Upon reaudit the practice demonstrated improvements, with 100% of monitoring carried out.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes ¹
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes ¹
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes ²
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence:	
<p>¹ In November 2021, we found the practice did not have effective assurance processes for the monitoring of staff training. We also found the quality of appraisal records was variable.</p> <p>In December 2022 we found the practice had implemented and maintained effective arrangements to monitor and assure themselves that staff had the appropriate learning and development to carry out their roles. We saw that these took account of eLearning, internal and external training opportunities. They had implemented a standardised appraisal process to ensure all staff were supported in their personal and professional development. All staff had received an appraisal in the last 21 months or had an appraisal date planned in the next 6-8 weeks.</p>	
<p>² In November 2021, we found the practice did not have formal processes in place to assure themselves of the competence of staff employed in advanced clinical roles. At this inspection, we found the practice had taken action to address this. They had implemented a peer and case review process as well as carried out audits of prescribing activity alongside an improved appraisal processes to ensure the competence of staff employed in advanced clinical roles.</p>	

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes ¹
Explanation of any answers and additional evidence, including from clinical searches: ¹ During the remote review of clinical records, we saw evidence patients and their relatives were involved in end of life care discussions. The practice used Emergency Health care plan templates to record patient wishes and preferences. There was no evidence seen of discrimination when treatment decisions were made.	

Responsive

Rating: Good

Responding to and meeting people's needs

The data and evidence we reviewed in relation to the responsive key question as part of this inspection did not suggest we needed to review the rating for responsive at this time. Responsive remains rated as good

Access to the service

People were able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
Explanation of any answers and additional evidence: The practice continued to monitor and seek improvements to access for patients. They were aware that access remained a key issue for General Practice and was an important marker for patient satisfaction. They had carried out an audit to check access indicators, such as whole time equivalent of GPs, number of GP sessions and appointment availability.	

Well-led

Rating: Good

At the inspection which took place in November 2021, we rated the practice as requires improvement for providing well led services because:

- Some aspects of the provider's governance systems were more informal and were not supported by auditable documented systems.
- The provider did not always act on appropriate and accurate information. We found performance information was not always used to hold staff and management to account.

At this inspection (December 2022), we found the practice had made significant improvements to the governance and assurance processes. The practice had acted upon the areas identified in the previous CQC inspection report and made good progress. The practice had used the previous inspection findings as a driver for improvement.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: The practice had a strong plan for succession, which they flexed on an ongoing basis to ensure it continued to support the practice both now and in the future. We saw that GP partners were supportive of each other and worked together to ensure there was leadership across the practice. The staff interviews and questionnaires we received also reflected staff felt they worked well together as a team and that they felt well supported by the practice leadership team.	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes

Explanation of any answers and additional evidence:
 The practice mission statement was:
 “We aim to be the practice of choice in our area by offering an excellent clinical service with a strong emphasis on customer care.

We will all belong to a team of multi – skilled professional staff with shared goals and objectives, as well as effective communication pathways.

Our aim is to work towards a more patient centered service supported by continuous professional and personal development for all members of our team”

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes ¹
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: ¹ The practice provided us with examples where they had ensured they met the requirements of the duty of candour. They demonstrated they had reflected on this area to ensure they could respond to the requirements of the duty of candour and to patients in a respectful and dignified way.	

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Staff interviews and questionnaires.	Staff told us they liked working at the practice and thought they worked well as a team. They told us they felt supported by leaders and managers in the practice. Where they identified risks or ways the practice could improve, action was taken to support them to work in a safe and effective way.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Explanation of any answers and additional evidence:	
<p>In November 2021, we found some governance arrangements were more informal which had made it more difficult for the practice to maintain these systems and effectively manage risks, issues and performance. In December 2022, we found the practice had addressed these concerns. They had formalised and improved governance arrangements. We saw evidence of this improvement in the governance of significant events; staff training, competence checks and appraisal processes; monitoring of high-risk medicines and long-term conditions; and, management of patient safety and medicine alerts.</p>	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial ¹
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence:	
<p>¹ Although leaders and the practice management team were aware of the risks to the practice and had arrangements in place to mitigate any risks, there were no formal risk management arrangements in place.</p>	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence: The practice now maintained accurate information about patient safety and medicines alerts, staff competence levels and staff training. They had addressed the concerns about the management of high-risk medicines, coding of patients and the monitoring of patients with long term conditions. We found performance information used to hold staff and management to account.	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Staff are supported to work remotely where applicable.	Yes

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes

Feedback from Patient Participation Group.

Feedback
There was positive feedback from a group member about the responsiveness of the practice to issues raised, good access to the practice, professional and efficient staff and good involvement of patients in decisions about care and treatment.

Continuous improvement and innovation

There were evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: At this inspection (December 2022), we found the practice had made significant improvements to the governance and assurance processes. The practice had acted upon the areas identified in the previous CQC inspection report (November 2021) and made good progress. The practice had used the previous inspection findings as a driver for improvement.	

Examples of continuous learning and improvement

- The practice routinely carried out clinical audit and carried out quality improvement initiatives to drive improvement.
- The practice was a part of a local Primary Care Network (North Gosforth Primary Care Network) to support the delivery of national service specifications and consider and develop a wider range of services and to more easily integrate with the wider health and care system.
- They participated in local initiatives, such as the local prescribing and diabetes prevention programme.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a SICBL average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a SICBL average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ‰ = per thousand.