

Care Quality Commission

Inspection Evidence Table

GP Practice at Riverside (1-2866464538)

Inspection date: 9 - 12 November 2020

Date of data download: 12 November 2020

This was a focused assessment undertaken remotely using pilot methodology for a GP focused inspection. We looked at areas within the domains of Safe, Responsive and Well Led.

Overall rating: Not applicable

We carried out a GP Focused Inspection Pilot remotely for this assessment and therefore we could not rate or amend ratings for the practice at this time.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe

Risks to patients

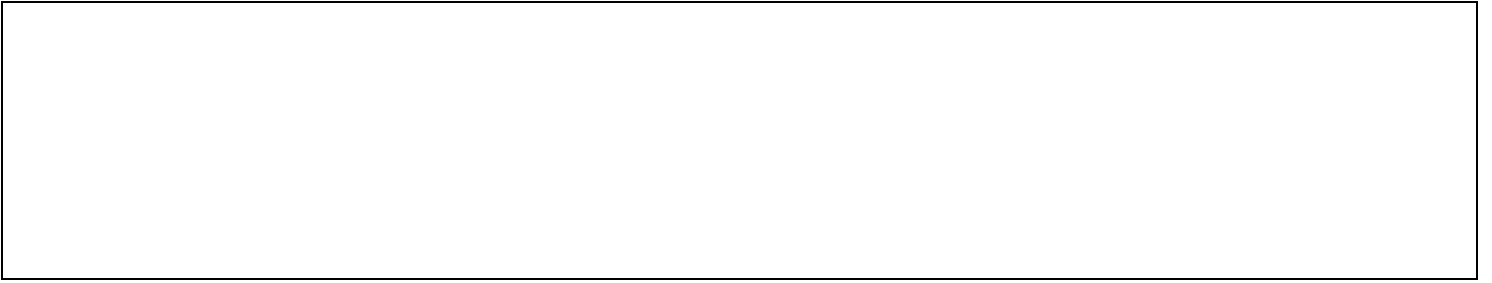
The systems to assess, monitor and manage risks to patient safety were not adequate.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
There was an effective induction system for temporary staff tailored to their role.	N
There was a process in the practice for urgent clinical review of such patients.	Partial
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Partial

Explanation of any answers and additional evidence:

- Overall, staff told us that they felt patients had their needs met and that care was prioritised depending on the risks to patients.
- Staff said the workload was high and stress levels were high. Clinical staff absences amongst the advanced nurse practitioners and paramedic were not covered by bringing in additional staff, and existing staff had to provide cover for their colleagues, which increased their workload.

- The pharmacist support across the organisation had reduced over the last three years. During clinical staff interviews concerns were raised that the workload for the pharmacist role was excessive. We were told that there was not enough time to undertake annual reviews of patients' medication or for the monitoring and auditing of medicines. Concerns were raised that prescriptions were not being reviewed or actioned appropriately.
- The provider was aware further staff were needed across their group of practices, however they were finding it difficult to recruit.
- Locum clinicians worked at the practice. A number of locum clinicians spoken with told us they had not had a formal induction.
- There was no system to determine how many staff or the skill mix needed to meet patient demand.
- There was no system to assess the effectiveness of the service offered. For example, the service provided depended on reception staff allocating patients to the correct computer list in order for patients to receive the correct service. This included triage, mental health services, fit note, medication requests, review of results. Urgent needs were highlighted by the reception staff for clinicians to review as a priority. Although most staff told us this system worked well and that there were informal checks of the triage board daily, there was no formal audit to ensure receptionists correctly allocated patients to the appropriate list. Feedback to us from clinicians was that at times it was difficult to identify the priority of the request quickly.
- We were told that the triage board is reviewed at regular intervals throughout the day. At the end of the day if a patient call has not had a response from a clinician this was sometimes passed to the following day for follow up. The provider did not have any formal arrangements in place for when this took place and the number of times this had occurred were not monitored.
- Clinicians told us that a WhatsApp group (mobile telephone group communication application) was used to communicate about any shortfalls in the service daily. As a result, clinicians could be called upon to offer a service to a patient from a practice they do not normally work at. There was no procedure in place for clinicians to help other practices when the workload was great. There was no procedure for moving patients to another service from the one they were registered at.
- Communication of urgent patient needs was via the triage board and a WhatsApp clinical group. Reception staff told us they had received training and were able to identify those in urgent need. They would refer to the appropriate clinician via the triage board model and inform the clinician of the urgent need.



Information to deliver safe care and treatment

Improvements were needed to ensure staff had the information they required to deliver safe care and treatment.

	Y/N/Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	N
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• There was no documented procedure for the processing of laboratory results. Staff reported that there was no formal procedure in place. Administrative staff brought urgent results to the attention of clinicians by allocating them to a computer-based list to be checked daily. There was no system to check that results had been appropriately prioritised or that all had been reviewed.• A WhatsApp group of senior staff and clinicians from across the providers practices was in place. This was used for a number of purposes, one being to communicate with clinicians when a practice did not have enough clinicians to undertake the work of the day, for example, provide an appointment or telephone a patient. As a result, a clinician could be called upon to offer a service to a patient from a practice they do not normally work at. There was no procedure for moving patients to another service from the one they were registered at. For example, to check that the patient was happy with this as their records would be shared with another service, to ensure time to review patient history before the appointment.	

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines.

Medicines management	Y/N/Partial
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.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	N
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The provider employed GPs, advanced nurse practitioners, a paramedic, pharmacist and pharmacist technician and practice nurses to work at this practice. A number of these clinicians also worked at other services operated by the provider. Staff told us that they were aware that the provider checked their consultation records and prescribing practices. However, they did not always receive feedback. This was informal and there was no record maintained. • We undertook a number of searches of the practice computer system and found that improvements were needed to the system to ensure patients received timely reviews of their long-term medication. We also found there was no formal process for identifying patients who needed a medication review. • We found there was a good system in place for monitoring the prescribing of disease-modifying antirheumatic drugs (DMARDs). However, a number of other medicines were not being appropriately reviewed and patients safely monitored as required. • A further review of the practice computer system identified there were some examples of potentially missed diagnosis for patients and this had not been picked up by the practice. • Staff interviews indicted they were concerned that excessive workloads increased the risk that patients who needed closer monitoring might not have this actioned. 	

Track record on safety and lessons learned and improvements made

Improvements were needed to the systems to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	5
Number of events that required action:	5
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Staff we spoke with told us they knew how to report a significant event. There was a procedure in place to support staff, however, this was not sufficiently detailed and there was not a robust system for sharing the findings from these events. There were no records to demonstrate how this learning was shared. Clinicians told us they were not always involved in the investigation of the significant events relating to their practices so did not feel involved in the process. The procedure for the management of significant events did not include examples of what would be a significant event so as to provide guidance for staff. It did not provide details of how it would be investigated, how learning and any subsequent actions would be shared with all relevant staff. It did not refer to carrying out a periodic analysis to look for patterns and trends. The arrangements for identifying, recording and managing risks, issues and mitigating actions were not robust and were not monitored appropriately. Where risks were identified, there was a lack of evidence to show that appropriate measures were taken within a timescale that reflected the level of risk and impact on people using the service. 	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	
There was a system in place to respond to alerts concerning patient safety. Clinicians employed by the provider told us that patient safety alerts were made available to them. Some locum clinicians told us	

they were not sent details of these alerts. We saw examples of actions taken on recent alerts for example, regarding sodium valproate.

Responsive

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Partial
There were arrangements in place for people who need translation services.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had introduced a new system to manage patient access to services. This was introduced last year. This included a triage service whereby patients calling on the day would get a telephone call from a clinician. This mostly happened on the same day. Occasionally this would occur the next day or a clinician from another service would be asked to attend to the patients' request. There was no formalised procedure for this. Staff reported that patients were positive about this new way of accessing the service. However, patient feedback had not been formally sought, for example via a questionnaire. Patients had good access to mental health services at this practice. A dedicated mental health clinician and support was available most days. They were able to prioritise and treat patients well and able to signpost and refer them on the secondary care and support as needed. The practice's website had links to translation services and enabled translation of the website information. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm The practice offers additional appointments from 7.15am until 8am every Tuesday.
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2020 to 31/03/2020)	91.7%	95.3%	94.2%	No statistical variation

Timely access to the service

People were not always able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had a triage system. Patients spoke to a receptionist who took the presenting information and allocated the patient to a triage list. The system in place required receptionists to identify any patients needing urgent attention so that the clinician could prioritise their needs. The clinicians reviewed the patients on the triage list and either offered a telephone, video consultation, home visit or a face to face appointment. Receptionists booked appointments for patients who needed to see a practice nurse, a mental health practitioner or receive childhood immunisations. There was a system for the pharmacist to manage medication requests and for clinicians to manage fit notes, urgent results, referrals and contact other services about patient care. The receptionists also sign posted patients to other services when they did not require general practice-based services, such as to a local pharmacy. The aim of the model was for patients to expediently access the appropriate clinician who could help them manage their condition. However, feedback to us from some clinical staff was that it was sometimes difficult to identify the priority of the patient request promptly. Overall, staff told us that they felt patients had their needs met and that care was prioritised depending on the risks to patients. There was no system to determine how many staff or the skill mix needed to meet patient demand. There was also no system to assess the effectiveness of the service offered. For example, the model in place depended on reception staff allocating patients to the correct 	

computer list in order to get a service. Although most staff told us this system worked well. No checks were done to ensure receptionists were doing this correctly.

- Clinical staff said the workload was high. Clinical staff absences amongst the advanced nurse practitioners and paramedic were not covered with additional staff, and existing staff had to provide cover for their colleagues, which increased their workload. During clinical staff interviews concerns were raised that the workload for the pharmacist role was excessive. The provider told us they were aware further staff were needed across their practices.
- Clinicians told us that the WhatsApp group was used to communicate about any shortfalls in the service on a daily basis. As a result, they could be called upon to offer a service to a patient from a practice they do not normally work at. There was no procedure in place for clinicians to help other practices when the workload was great. There was no procedure for moving patients to another service from the one they were registered at.
- In response to the Coronavirus pandemic the Practice had temporarily suspended appointments that could be booked on-line through offered through Patient Access/My GP Services.

Indicator	Practice	CCG average	England average	England comparison
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 (01/01/2020 to 31/03/2020)	52.9%	N/A	65.2%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	46.5%	66.9%	65.5%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2020 to 31/03/2020)	37.4%	67.2%	63.0%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	48.7%	74.1%	72.7%	Tending towards variation (negative)

Any additional evidence or comments

The triage model was introduced to the practice last year. Patient feedback had not been formally sought, for example via a questionnaire to see if patients considered this new approach met their needs.

Source

Feedback

For example, NHS Choices	5 reviews had been left since October 2019. Four of the reviews referred to improvements being needed to access. They referred to delays in getting through to the practice by telephone or difficulty in getting an appointment.
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Listening and learning from concerns and complaints

Improvements were needed to how complaints were responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	5
Number of complaints we examined.	1
Number of complaints we examined that were satisfactorily handled in a timely way.	Partial
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We looked at the procedure for the management of complaints. This detailed the process for staff to refer patients to and included timescales and external organisations that patients could approach. We looked at one complaint. This responded to the issues raised by the complainant, however it was not dated, and it did not direct the complainant to the Parliamentary Health Service Ombudsman (PHSO) should they have been dissatisfied with how the practice had dealt with the issues raised. The complaint was not investigated by the complaint lead and there was no record that this was overseen by them. There was no documented audit trail of the steps taken and the decisions reached. Some of the staff interviewed told us there was no formal feedback of complaints to staff unless they were involved in the complaint. 	

Well-led

Leadership capacity and capability

Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a senior management structure identified and documented which was led by the provider. This included managers for different areas including clinical, human resources, finance, governance and communications. The provider was the only senior clinical leader identified in this team and they did not have a clinical deputy or any contingency plans in place for his absence, planned or unplanned. • The provider and members of the senior management team interviewed had some understanding of the issues and concerns around staffing and quality monitoring. They understood that they did not have enough staff and had to utilize a number of long-term locum clinicians. However, they had not formally monitored, analysed or reviewed staffing ratio/dependency needs or the triage model of care and treatment in place. • Most of the staff interviewed reported that leaders and senior managers were visible and accessible, and they felt well supported by them and by their line managers. They reported they were able to contact senior managers when needed, especially the provider who was available by telephone, if not on site. However, some staff reported that they did not feel very well supported and concerns raised were not dealt with relating to staffing levels and the clinical cover at this practice. • The provider told us about plans he had for development of the leadership, management and governance structure for the next few years, however these were not yet formalised or in place. Staff told us that the provider supported them in their professional development and in the development of their leadership/management skills 	

Vision and strategy

The practice had a clear vision, but it was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial

The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The provider could articulate their vision and values for providing high quality, accessible care and treatment through a triage model approach using a multi-disciplinary team of skilled clinicians. • We saw strategies to support the priorities including communications, culture, winter pressures, Covid19 strategies, however the strategies supporting this vision and values were not robust or detailed enough. They had not been developed in conjunction with staff and were not reviewed or monitored. Progress against delivery was not monitored. • Staff could articulate their passion for their work and their ethos and values. They enjoyed working at the practice and enjoyed the good teamwork there. However, they were not aware of a formal strategy and this had not been communicated well enough with them. 	

Culture

The practice had a supportive culture, however improvements were needed in order to drive high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	N
The practice had access to a Freedom to Speak Up Guardian.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The organisation and the practice were supported by a culture strategy. Arrangements were in place to deal with any concerns about behaviour or performance. The human resources lead member of staff could describe performance management and support given to individuals. Staff reported that they felt able to raise concerns without fear of retribution. They knew about the whistle blowing policy and procedures and would raise concerns if needed. They were confident that concerns would be dealt with appropriately and knew how to access external support if needed. The practice had a whistle blowing policy, however, staff did not have access to a Freedom to Speak Up Guardian. The policy names CQC and the GMC as external bodies employees could refer their concerns to. It did not provide the contact details of these organisations. The provider had taken steps to promote a positive culture at this practice. They had put in place a newsletter for staff which began in December 2019. This provided information for staff about operational issues, clinical updates, staffing, updates on policies and procedures, training, and staff welfare matters. The provider had an employee of the month system to recognise the achievement of staff. The provider also had a documented policy for obtaining staff feedback, for example, through annual engagement meetings and encouraging feedback via the newsletter by providing contact details of relevant staff. Staff generally felt that the practice and the organisation they worked for was open and honest. We found that improvements were needed to how patient and staff complaints were managed to ensure there was appropriate oversight, recording and patients knew what to do if they were dissatisfied with how their complaint was managed. 	

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

Source	Feedback
Staff interviews	<p>Staff told us that the focus of the practice was on patient care and ensuring patients got their needs met. They told us that the provider was passionate about the service provided. They said patients had their needs met and that the service was safe.</p> <p>Some staff told us they would like to feel more involved in the day to day operation of the practice. Staff said they felt able to raise concerns. The clinical staff told us that the workloads were high and there was more patient demand than there were staff available.</p>

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Staff were clear about their own roles and responsibilities, they had job descriptions and told us they worked well as a team in the practice. They were aware of who to go to, clear as to who their line management was and how to escalate issues. The governance framework was not clearly defined or identified. Arrangements for reviewing governance systems needed to be improved. There was insufficient review, analysis and a lack of action planning and review. Overall responsibility for risk management was not clear. The job description of the head of governance did not refer to how good governance would be implemented and governance documents did not detail oversight, responsibility, review, monitoring and escalation processes. Some of the policies and procedures that we looked at required review and improvements. The governance protocol did not refer to monitoring of all aspects of the service such as how access is monitored to ensure there are enough staff. The recruitment procedure did not contain all the required checks that needed to be carried out. The whistle blowing procedure did not include the Freedom to Speak UP Guardian details and the significant event procedure was not sufficiently detailed. The procedure for the management of significant events did not include examples of what would be a significant event so as to provide guidance for staff. It did not provide details of how it would be investigated, how learning and any subsequent actions would be shared with all relevant staff. It did not refer to carrying out a periodic analysis to look for patterns and trends. 	

- The complaint procedure did not sufficiently detail how investigations would be undertaken and by whom. A policy and procedure was not in place for the safe use of personal telephones for the What's App Group and for the use of the What's App group for communication. The policies were not dated and did not have a responsible person or a review date.
- There was a lack of procedures and protocols for significant processes. For example, there was no formal process for identifying patients who needed a medication review, and many were out of date. There were concerns that the system whereby lab results were processed was not formalised and so results could and had been missed.
- There was no standard operating procedure (SOP) or protocol in place for clinicians to help other practices when the workload was excessive. There was no procedure for moving patients to another service or for moving patients over to next day appointments if needed.

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	N
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a lack of assurance that there were robust arrangements in place for identifying, recording and managing risks, issues and mitigating actions. There was a lack of assessing, monitoring and evaluation of service and service developments. • Staff said the workload was high. Clinical staff absences such as holidays were not covered, and existing staff had to cover their colleagues. The provider was aware further staff were needed, however, there had been no formal review of staffing levels, mix and ratios. The provider told us they were trying to recruit; however, it was proving difficult to do so. • There was no system to determine how many staff/skill mix ratios of staff were needed to meet patient demand or to assess the effectiveness of the service offered. • Staff appraisals took place on a regular basis, however formal clinical supervision did not take place. Locum clinical staff were not part of the lines of communications within the practice or organisation e.g. emails / WhatsApp group or the governance framework for the practice. Locum clinical staff did not have appraisals with the practice and there was little evidence their work had been reviewed or audited We were told this was done informally. • The system in place for monitoring and auditing the practice required improvement. The audit plan referred mostly to medicine audits and had recently been implemented so that improvements from audits could not be demonstrated yet. The audit plan did not demonstrate that it was based on local, national or service priorities. • The arrangements for reviewing and investigating incidents and significant events was unclear. The human resources manager coordinated and shared these with some of the relevant people. There was no evidence that incidents were discussed at clinical meetings, staff reported poor feedback or a lack of feedback when things went wrong. • There was a WhatsApp group for communications including triage requests. These groups were relied upon by the organisation, however there was no Standard Operating Procedure (SOP) or protocol to support its safe use. A number of staff members were using their own phones for the groups, no assurance systems were in place that these phones were password protected, safe and secure. 	

- No formal documented meetings took place. These had been in place with training and development sessions occurring once a month, however since the onset of the pandemic these had not been occurring. No formal clinical supervision took place for clinical staff. Clinical meetings were taking place informally and clinical supervision was informal.
- The triage model of care and treatment had been introduced to the practice last year. This model relies on reception staff making decisions and allocating patients appropriately to members of the multi-disciplinary team. Reception staff had been trained in the triage model by a clinician and were confident in its use. Staff told us they felt patients had their needs met and overall care was prioritised depending on need. However, this model of care had not been formally reviewed, analysed or improved since its inception to ensure effectiveness and safety.
- The provider did not have effective systems in place for handling, considering, monitoring, reviewing and responding to complaints. This include both complaints made by staff members and complaints made by patients and members of the public.

Engagement with patients, the public, staff and external partners

The practice did not always involve the public, staff and external partners to sustain high quality care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
Staff views were reflected in the planning and delivery of services.	Partial
Explanation of any answers and additional evidence:	
<p>Patients views were invited. The website gave details of how to complain and how to provide other feedback or suggestions.</p> <p>Staff told us they had received positive feedback from patients regarding the new triage model of care and felt they were able to access appointments at a time convenient to them. The triage model was introduced to the practice last year. Staff reported that patients were positive about this new way of accessing the service, however, patient feedback had not been formally sought, for example via a questionnaire.</p> <p>Staff reported that there had been changes in service over recent months. They felt they could have been involved more and communications could have been better.</p> <p>Staff told us they felt their manager was approachable and would listen to any feedback they would give, however there was limited opportunity as formal documented meetings did not take place on a regular basis.</p>	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence:	
<p>There was a lack of formal documented meetings at which significant event analysis, incidents and complaints learning could take place. The practice used to have monthly development days however since the onset of the pandemic these have not occurred.</p> <p>Staff reported that they lacked feedback from significant events and complaints. Locum staff who worked at the practice were not always included in the significant event, incidents and complaints learning process.</p>	

An appraisal system was in place for staff and appraisals took place annually. However, locum staff did not have a formal system of appraisal or formal review of their work. There was no formal induction for locum staff. Locums did not have access to the organisations policies and procedures.

A number of staff told us they were supported with their ongoing continuous professional development and they felt supported by the provider. Others reported that there wasn't enough time to attend meetings and not all clinical staff were part of the WhatsApp clinical improvement group.

The system in place for auditing the practice required improvement. Mostly the audits shown referred to medicines and the full range of audits and monitoring activities could be expanded. It was not clear that local national and service priorities were prioritised.

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 practices 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 CCG 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 CCG 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
- **PHE:** Public Health England
- **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.