

Care Quality Commission

Inspection Evidence Table

The Glebe Family Practice (1-543663357)

Inspection date: 08 September 2022

Date of data download: 06 September 2022

Overall rating: Requires Improvement

We rated the practice as Requires Improvement overall because:

- Improvements were needed to the systems and processes designed to keep people safe.
- The practice's systems for the appropriate and safe use of medicines required improvement.
- The practice's systems and processes did not allow the practice to effectively act on safety alerts.
- Improvements were needed to the practice's system for monitoring patients with long-term conditions.
- The practice's processes did not always effectively manage risks, issues and performance.

Safe

Rating: Requires Improvement

We rated the practice as Requires Improvement for providing safe services because:

- Improvements were needed to the systems and processes designed to keep people safe.
- The practice's systems for the appropriate and safe use of medicines required improvement.
- The practice's systems and processes did not allow the practice to effectively act on safety alerts.

Safety systems and processes

The practice had some systems, practices and processes to keep people safe and safeguarded from abuse. However, some improvements were needed.

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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a designated safeguarding lead and deputy. All staff knew how to identify and report concerns. There were safeguarding policies that were accessible to staff and outlined who to contact if staff had concerns about a patient's welfare.</p> <p>We looked at the training records of five staff members and found that all staff were up to date with safeguarding training appropriate to their role.</p> <p>The practice's computer system alerted staff of children that were on the risk register. We found that the practice's system did not alert staff to all family and other household members for one child on the risk register. However, during our inspection the provider instructed staff to add relevant alerts to all family and household members records of children who were on the risk register. We saw that this had been completed.</p> <p>There were notices in the practice waiting room and clinical rooms advising patients that chaperones were available. We saw that staff who acted as chaperones were trained for the role</p> <p>We saw that staff had received Disclosure and Barring Service (DBS) checks (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The DBS checks that we viewed for five members of staff were older than three years old, therefore the provider had completed risk assessments for each staff member, as per their safeguarding policy. The provider told us that they were currently updating their policy to determine the frequency at which DBS checks should be completed.</p>	

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
<p>Explanation of any answers and additional evidence:</p> <p>We looked at the vaccination records of five members of staff and found that there were incomplete records for three members of staff. For example, we did not see evidence of measles, mumps and rubella (MMR) or Bacillus Calmette-Guerin (BCG) vaccinations for one clinical staff member. We did not see evidence of BCG or varicella vaccine for another clinical staff member. We also could not see if a non-clinical staff member had immunity against MMR, tetanus, diphtheria or polio. The provider</p>	

told us that they were in the process of collating information on staff immunisations.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 23 September 2021	Yes
There was a fire procedure. Date of fire risk assessment: 23 September 2021	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Records showed that portable appliance testing (PAT) had been carried out within the last 12 months. The most recent calibration testing of equipment took place in August 2021; however, we saw evidence that this testing had been booked for 8 September 2022.</p> <p>We saw the provider had completed a fire risk assessment on 23 September 2021. The risk assessment identified four actions that the provider needed to take. For example, a fire safety and evacuation plan needed to be completed by a competent person. We saw evidence that this and two of the other actions had been completed. One action remained incomplete: fixed wired testing should be carried out every five years. The provider told us that this needed to be completed by the landlord of the premises and was scheduled to take place.</p> <p>The provider recorded tests and inspections for the emergency lighting system, fire extinguishers and means of escape. We saw evidence that the emergency lighting system was tested every 6 months, the last test was on 19 May 2022 and was satisfactory. Fire extinguishers and means of escape were tested monthly, records from the last twelve months showed that these tests were satisfactory.</p> <p>We looked at the training records of five members of staff and saw that all had received training in fire safety.</p> <p>The provider had a fire evacuation plan and carried out fire drills. The most recent fire drill was completed 25 April 2022 and concluded that all was satisfactory. There were designated fire marshals who were up to date with their fire marshal training.</p> <p>The provider did not have a health and safety poster displayed in the practice. After the inspection, the provider wrote to us with evidence that a health and safety poster had been purchased for display in the practice.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met, however some improvements were required.

	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: 31 August 2022	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
<p>Explanation of any answers and additional evidence:</p> <p>The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. We looked at the training records of five staff members and saw they had received appropriate training in infection prevention and control (IPC).</p> <p>Records showed the provider had completed an IPC audit which identified actions that the provider needed to take. For example, it was recommended that an audit was needed to monitor the cleaning of reusable medical devices. We did not see evidence that the provider had recorded that these actions had been completed. However, following the inspection the provider wrote to us with evidence that 10 of the 12 identified actions had been completed. The two remaining actions related to staff training, and although these had not yet been completed, dates for completion had been set.</p> <p>The provider had identified some areas of the practice had carpeted floor. Sinks in clinical rooms did not meet the appropriate standards for use in a healthcare setting. We saw that a mat by a fire exit was not secure and posed a trip hazard. After the inspection, the provider wrote to us with evidence that the mat had been secured. The provider had arranged for carpeted floor to be removed and sinks to be replaced at the next refurbishment of the practice. A risk assessment had been completed in order to reduce the risks associated with these fittings. The provider had a comprehensive action plan to mitigate any risks relating to IPC, such as contamination from spills.</p>	

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
<p>Explanation of any answers and additional evidence:</p> <p>There was an induction system for all new staff. The performance of new staff was monitored via regular one to one meetings with an appointed staff member.</p> <p>The practice had a comprehensive business continuity plan for major incidents such as; power failure or building damage. The plan included emergency contact numbers for staff.</p> <p>We looked at the training records of five members of staff and saw that all five had completed basic life support training appropriate to their role.</p> <p>We saw there was an inventory of emergency equipment and that regular monitoring took place. The provider held one set of adult defibrillator pads and one set of paediatric defibrillator pads. After the inspection, the provider sent us evidence that an additional set of each type of defibrillator pads had</p>	

been purchased for use in the practice.

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
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: Review of patient records identified that care records were managed in line with current guidance. All incoming documents were managed by the named GP. Referrals were appropriate and managed in a timely manner.	

Appropriate and safe use of medicines

The practice's systems for the appropriate and safe use of medicines required improvement.

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.70	0.85	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). (01/07/2021 to 30/06/2022) (NHSBSA)	5.7%	8.9%	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 (01/01/2022 to 30/06/2022) (NHSBSA)	5.01	5.77	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	125.1‰	132.5‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.58	0.61	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	5.0‰	6.9‰	6.8‰	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
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	N/A

Medicines management	Y/N/Partial
supervision or peer review.	
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. ¹	Yes
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. ²	Yes
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.	No
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
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.	Partial
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>The provider held controlled drugs on the premises. However, we found that these were not stored in line with best practice guidance. We found four vials of cyclimorph 10 injection and 10 vials of morphine sulphate injection stored in a locked cupboard in an unlocked treatment room. The provider held a controlled drug register. After the inspection, the provider wrote to us with evidence of written standard operating procedures covering all aspects of controlled drug management. Following our inspection, the provider told us that they had taken the decision to remove all controlled drugs from the premises. We were sent evidence that the provider had destroyed the controlled drugs found at the practice in line with the Department of Health guidance on destruction of controlled drugs.</p> <p>We found that blank prescription forms were kept in an unlocked cupboard. We told the provider this, the blank prescription forms were then moved to be stored in a locked cupboard. The provider did not keep a log of the prescription forms that had been received or were being held, and there was no record to show how the forms were tracked through the practice. However, after our inspection the provider wrote to us with evidence that they now had a protocol for the recording and checking of prescription pads throughout the practice. This included recording serial numbers when prescription forms arrived at</p>	

Medicines management

Y/N/Partial

the practice and that the forms were to be held in a locked cupboard in a lockable room.

We looked at five Patient Group Directions (PGDs) and found that staff had the appropriate authorisations to administer medicines. However, additional signatory lines on all five PGDs had not been scored through to ensure no further signatures could be added. We told the provider of these findings, who subsequently corrected the error and showed us evidence of the PGDs having been completed correctly.

We reviewed the records of five patients who had been prescribed methotrexate (an immunosuppressant) and found that monitoring of these patients was in line with best practice guidance.

We reviewed the records of five patients who had been prescribed a potassium sparing diuretic. We found that four of these patients were overdue the required monitoring tests. We saw evidence that the provider had attempted to contact three of these patients to arrange the necessary tests. Following our inspection, the provider showed us evidence that all four patients had been contacted to arrange the appropriate monitoring.

We looked at five patients who had 10 or more prescriptions for benzodiazepines. We found the patient records for two of these patients did not include details of consultations where medicines were issued on acute prescriptions. After the inspection the provider wrote to us with evidence that these two patients had been contacted and had appointments scheduled to discuss appropriate monitoring. The provider also told us that the procedure for issuing acute prescriptions of benzodiazepines had been reviewed. All acute drug issues were highlighted when requested with the date of the last issue. The GP reviewed the notes and decided whether the continued prescription was appropriate or whether the patient needed to be contacted for a review.

We looked at five medicine reviews and found four reviews had been completed in line with best practice guidance. One patient was due a review following a change to the dose of their medicine. The provider sent us evidence that this patient had been contacted to attend for a review.

We saw there was an inventory of emergency medicines held and regular monitoring took place. The provider did not hold the following emergency medicines; dexamethasone 5mg/2.5mg oral solution or soluble prednisolone; diclofenac intramuscular injection; glucagon or glucogel; or midazolam buccal or rectal diazepam. There were no risk assessments to show why these medicines were not held. After the inspection, the provider sent us evidence that these medicines had been purchased for use in the practice.

The provider held medical oxygen and a defibrillator on site, we saw evidence of regular monitoring of these.

The provider had four refrigerators for the storage of vaccines. The temperatures of these refrigerators were monitored and recorded regularly. Records showed that the temperature of one of the refrigerators had been recorded as being outside of the acceptable limits of between two and eight degrees centigrade on 9 and 10 August 2022. We told the provider of these findings. The provider checked the internal thermometer to retrospectively check the refrigerator temperature on these dates, which stated that the temperature remained between the recommended range. However, we did not see evidence of any action taken when the out of range temperature was recorded. After the inspection, the provider sent us evidence of a significant event form that had been completed for this incident. The significant event record stated that the cold chain policy had not been implemented correctly. The protocol for action to be taken was reviewed and updated, this was shared with all staff. The provider had arranged in-house training for all staff with responsibilities for checking refrigerator temperatures.

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:	8
Number of events that required action:	8
Explanation of any answers and additional evidence: We looked at four significant events that had been recorded within the last 12 months. We saw that details of the events had been investigated, escalated to the GP partners where necessary, discussed in clinical meetings and action taken. We saw that lessons learned were shared with staff via email.	

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

Event	Specific action taken
A patient attended for a procedure that required a sample to be taken using a swab. However, after the patient had arrived, the provider discovered that swabs were not available for the procedure.	Patient received a verbal apology and was booked for a repeat appointment after the practitioner confirmed that a delivery of swabs would arrive the following day. The appointment was successfully carried out the following day. The provider amended the way in which stock was ordered and allocated staff to be responsible for stock checks and ordering.
Covid vaccine was incorrectly mixed.	Six doses of the unused vaccine were disposed of and additional stock was ordered. The staff member involved reviewed their training on vaccines to prevent reoccurrence.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: The practice had a system for receiving, sharing and acting on safety alerts. Staff we spoke with understood how to process these alerts. We looked at the records of five patients who had been prescribed clopidogrel and omeprazole or esomeprazole and found that there was no record that these patients had been advised of the interaction between the medicines (which reduces the effectiveness of clopidogrel). We shared these	

findings with the provider who told us that this had now been addressed with the relevant patients.

Effective

Rating: Requires Improvement

We rated the practice as Requires Improvement for providing effective services because:

- Improvements were needed to the practice's system for monitoring patients with long-term conditions.

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, but care and treatment was not always 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
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Partial
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 had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence: We saw evidence that patients were coded onto appropriate registers. For example, patients with a learning disability were coded as such, which enabled the provider to identify those patients in need of a learning disability check. The practice ran a telephone triage system which enable patients to be signposted to appropriate services and ensure same day access for the assessment of urgent problems. We saw evidence that	

patients were signposted to NHS 111 or Accident and Emergency if their condition worsened.

During our inspection, we completed a series of searches on the practice's clinical records system. These searches were completed with consent and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance.

We reviewed five patients who had been prescribed two or more courses of rescue steroids and two patients with CKD stage 4 or 5 and found that best practice guidance had been followed for the management of these patients.

We reviewed five patients identified as having a potential missed diagnosis of Chronic Kidney Disease (CKD) stage 3,4 or 5. We found these patients had the potential diagnosis of CKD discussed with them, however all these patients were overdue monitoring tests. We shared these findings with the provider who told us that all patients had been contacted to attend for the required monitoring tests.

We looked at the records of five patients with hypothyroidism and found that four of these patients had not had thyroid function test monitoring for 18 months. We shared these findings with the provider who wrote to us with evidence that all patients had been contacted to attend for a review.

We looked at the records of five patients with diabetic retinopathy (diabetic retinopathy is a complication of diabetes, caused by high blood sugar levels damaging the back of the eye. It can cause blindness if left undiagnosed and untreated). We found the eye screening appeared to be overdue for two of these patients, and another patient needed a follow up blood test appointment. The provider told us that the two patients who were overdue eye screening had appointments with the retinal clinic or eye hospital. The patient who needed the follow up blood test had been contacted to attend for monitoring.

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 offered 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 and checks including NHS checks for patients aged 40 to 74. 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 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, including a mental health nurse who held clinics at the practice once per week

Management of people with long term conditions

Findings

- Patients with long-term conditions were offered a structured 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 was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability and dementia.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

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) (NHS England and Improvement)	33	34	97.1%	Met 95% WHO based target
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) (NHS England and Improvement)	43	44	97.7%	Met 95% WHO based target
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	42	44	95.5%	Met 95% WHO based target

31/03/2021) (NHS England and Improvement)				
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) (NHS England and Improvement)	41	44	93.2%	Met 90% minimum
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) (NHS England and Improvement)	46	54	85.2%	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

Childhood immunisations were carried out in line with the national childhood vaccination programme. NHS England results (published in March 2021) showed that uptake rates were higher than the World Health Organisation (WHO) target of 95% for three indicators and below the 90% minimum target for one indicator.

The provider told us that there had been an error in coding of some children aged 5 who had received immunisation for measles, mumps and rubella. This meant that the uptake rates for this indicator appeared to be lower than the 90% minimum target.

The provider told us they had a designated administrative lead who monitored uptake rates and contacted patients who had not attended for immunisations.

Cancer Indicators	Practice	CCG 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: 31/03/2022) (UK Health and Security Agency)	82.7%	N/A	80% Target	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	75.2%	63.4%	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)	72.9%	68.0%	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)	68.4%	56.4%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments

Published results showed that the provider's uptake for cervical cancer screening as at March 2022 was above the 80% target for the national screening programme.

The provider told us they had a designated cervical screening lead who contacted patients via letter and telephone to advise when screening was due. Alerts were placed on the practice's systems so that healthcare professionals used opportunistic appointments, when a patient attended the practice for other matters. Staff told us that where possible they accommodated the wishes of a patient who requested a particular healthcare professional to carry out their cervical screening. This was helpful to encourage patients who had fears or concerns about cervical screening.

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 two years

As part of this inspection, we asked the provider to submit a copy of any clinical audits carried out within the last 12 months. A clinical audit aims to improve the quality of patient care by looking to see if healthcare is being provided in line with standards. It can help identify improvements that may be needed.

The provider sent evidence of clinical audits that were part of an overarching programme. For example, a second cycle audit had been conducted to monitor high-risk antibiotic prescribing. The initial audit completed in November 2021 made recommendations to reduce the number of high-risk antibiotics prescribed for example, encourage the use of delayed prescriptions until a diagnosis is confirmed, and offer patient education. At the second cycle of this audit in April 2022, it was found that the recommendations had been successful in reducing the number of high-risk antibiotics. The outcome of this second cycle was that high-risk antibiotics were being used appropriately, and associated risks were effectively highlighted.

The provider had undertaken a case study as part of the Gillingham primary care network (PCN) which aimed to increase the number of available GP appointments. Guidance was produced for reception and administrative staff to enable staff to appropriately triage and signpost patients. Staff were trained in how to use the guidance and the outcome was measured by the number of appointments that were not booked. Further, an Advanced Nurse Practitioner was employed at the

practice. The case study indicated the provider increased the number of GP appointments available for patients by 10 appointments per week.

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
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
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
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had an induction programme for newly appointed staff and ongoing training for existing staff. Subjects covered included: basic life support, safeguarding, fire safety, information governance, infection prevention and control. Staff had access to e-learning training modules and in-house training.</p> <p>We looked at the training records of five members of staff. We saw two members of staff had not received training in fire safety, and an additional member of non-clinical staff had not received training in sepsis management or equality and diversity. After the inspection, the provider wrote to us with evidence that all three staff members had completed this training.</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-centered care when they moved between services.	Yes

Explanation of any answers and additional evidence:

Services provided through the primary care network, such as home visit, physiotherapist and social prescriber services were able to securely access patient records. DNACPR forms completed by the practice were emailed to the ambulance service for their information.

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 Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Yes

Explanation of any answers and additional evidence

We reviewed four patient records where a DNACPR decision had been recorded. This identified that where a DNACPR decision had been recorded, patient views had been sought and respected. We saw information had been shared with relevant agencies and there was a clear rationale for the decision that was not discriminatory nor based on assumptions about the person's quality of life.

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgmental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

Patient feedback	
Source	Feedback
NHS reviews website	There were four reviews on the NHS website. All of these reviews gave five out of five stars and were positive about the practice. Comments referred to professional and helpful staff and excellent service received.
Experience shared directly with CQC via our website	There was one comment received by CQC which raised concerns about reasonable adjustments available at the practice for people with disabilities.
Friends and Family Test	<p>The Friends and Family Test for:</p> <ul style="list-style-type: none">• June 2022 had 46 respondents, 42 of these responses were positive (91%).• July 2022 had 50 respondents, 49 of these responses were positive (98%).• August 2022 had 50 respondents, 48 of these responses were positive (96%). <p>Positive responses made reference to trusted and excellent healthcare professionals, welcoming and friendly reception staff, and good availability of appointments. One negative response referred to the need to chase test results.</p>

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	92.7%	82.1%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	87.2%	80.8%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	96.7%	92.0%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	81.7%	66.8%	72.4%	No statistical variation

Any additional evidence or comments

Feedback about the practice from the national GP patient survey published in April 2022 was positive and in line with local and England averages.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Yes

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	93.4%	89.0%	89.9%	No statistical variation

Any additional evidence or comments

Feedback about the practice from the national GP patient survey published in April 2022 was positive and in line with local and England averages.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	The practice had identified that there were 111 carers in the practice (2.4% of the practice population)
How the practice supported carers (including young carers).	The provider had a carers identification protocol which set out the mechanism for identification and support of carers. An alert was added to the carer's record so that carers could be supported with suitable appointment flexibility and understanding. Information was given regarding local authority resources and contact points.
How the practice supported recently bereaved patients.	Bereaved patients were directed to bereavement support services.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am-6pm
Tuesday	8am-6pm
Wednesday	8am-6pm
Thursday	8am-6pm
Friday	8am-6pm
Appointments available:	
Monday	8am-6pm
Tuesday	8am-6pm
Wednesday	8am-6pm
Thursday	8am-6pm
Friday	8am-6pm

Further information about how the practice is responding to the needs of their population

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Appointments were available outside of school hours so that school age children did not need to miss school in order to receive care and treatment.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Outside of the practice's working hours, patients were advised to call the NHS 111 service for urgent medical situations.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	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	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: There were multiple appointment types available, including face to face, telephone and video consultations. Patients were able to book appointments in person, on the telephone and via eConsult (online). The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs. On the day of inspection, we looked at the practice's appointment system and found that the next available face to face appointment with a GP was on 8 September 2022, the next available telephone appointment with a GP was on 8 September 2022 and the next available face to face appointment with a nurse was on 8 September 2022.	

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

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 (01/01/2022 to 30/04/2022)	78.6%	N/A	52.7%	Significant Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	70.1%	48.6%	56.2%	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 (01/01/2022 to 30/04/2022)	64.5%	48.2%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	77.2%	68.2%	71.9%	No statistical variation

Any additional evidence or comments

Feedback about the practice from the national GP patient survey published in April 2022 was positive and in line with local and England averages. Results showed higher than average satisfaction scores for patient satisfaction with how easy it was to get through to someone at their GP practice on the telephone.

Staff at the practice told us that they had acted on patient feedback about access to the practice. Patients said that there were too many telephone options when contacting the practice. The provider subsequently reduced the number of options which resulted in patients having a shorter wait time on the telephone. The provider also reviewed data about the times when phone lines were busiest and arranged staff schedules to meet demand.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	12
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	5
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient did not receive an appointment following a referral from the practice.	The provider apologised to the patient and gave a clear explanation that the referral had been completed incorrectly due to a change in procedure. The patient was advised that the referral had been corrected, and was later contacted by the hospital. The change in procedure was shared with staff at the practice.
A patient called the practice, was put on hold, and then the telephone was put down. The patient called back, however at that point the practice was closed for the day.	The provider accessed the phone records to investigate this complaint. The patient called the practice at the same time whilst staff checked the telephone system was set up to play the out of hours message. The provider apologised to the patient and gave a full explanation of why this happened. The complaint was shared with staff to raise awareness and prevent future occurrence.

Well-led

Rating: Requires Improvement

We rated the practice as Requires Improvement for providing well-led services because:

- The practice's processes did not always effectively manage risks, issues and performance

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 provider had taken part in a quality improvement initiative which aimed to increase the number of GP appointments available. This initiative had resulted in 10 additional GP appointments available each week and was reflected in the results of the most recent national GP patient survey results where patients responded positively when asked about their experience of making an appointment. National GP patient survey results also showed higher than average satisfaction scores for patient satisfaction with how easy it was to get through to someone at their GP practice on the telephone. Staff told us leaders were approachable, and they felt supported by the practice management 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: Staff told us they were aware of the practices' vision, values and strategy. They understood their role in supporting the development and achievement of these.	

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
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
<p>Explanation of any answers and additional evidence:</p> <p>Leaders modelled and encouraged compassionate, inclusive and supportive relationships among staff so that they felt respected, valued and supported.</p> <p>Staff told us there was an open culture within the practice and they had the opportunity to raise any issues and felt confident and supported in doing so.</p> <p>We reviewed the training records of five staff members and found that one member of staff had not completed training in equality and diversity. However, the provider wrote to us after the inspection with evidence that this training had been completed.</p>	

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

Source	Feedback
Staff interviews and feedback forms	The staff members we spoke to were positive about the leadership team and the ways in which the practice operated. Staff told us that roles and responsibilities of staff members were clearly defined and they knew who to approach for support. Staff felt comfortable speaking up and could give examples of where staff feedback had driven improvement.

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
<p>Explanation of any answers and additional evidence:</p> <p>We looked at 20 governance documents and found that they were up to date. The provider had a system to ensure the documents were reviewed regularly. Staff told us that all practice policies and procedures were accessible on the practice's shared drive and in printed form in the practice manager's office. Staff were informed when changes are made to policies and procedures.</p>	

Managing risks, issues and performance

There were processes for managing risks, issues and performance however, improvements were required.

	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
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
<p>Explanation of any answers and additional evidence:</p> <p>Our inspection identified that improvements were required in relation to the management of risks in relation to:</p> <ul style="list-style-type: none"> • DBS checks • Records of staff immunisation • Safety alerts • Blank prescription pads • Monitoring of refrigerator temperatures • Controlled drugs • Emergency medicines held on-site • Clinical coding relating to childhood immunisation records <p>We also found improvements to care and treatment were required for some types of patient reviews. For example:</p> <ul style="list-style-type: none"> • Patients who had been prescribed a potassium sparing diuretic • Potential missed diagnosis of Chronic Kidney Disease (CKD) stage 3, 4 or 5 • Patients with hypothyroidism • Patients with diabetic retinopathy <p>After the inspection, the provider wrote to us with evidence they had reviewed and taken appropriate action on all the above. They also shared a comprehensive action plan which detailed how they would monitor and improve systems and processes.</p>	

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients	Yes

during the pandemic.	
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice continued to operate throughout the pandemic providing a range of appointments including; face to face, video and telephone consultations, as well as home visits.</p> <p>The needs of vulnerable patients were coded as such on their patient records and offered longer face to face appointments.</p> <p>Reception and administrative staff had received training in triage to help ensure patients accessed the most appropriate appointment to suit their needs. As a result of this training and subsequent implementation, 10 additional GP appointments had been made available per week.</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

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

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
Explanation of any answers and additional evidence: The provider had an active patient participation group (PPG) who supported the practice to drive improvement. PPG meetings were used to share information with patients. Minutes of PPG meetings showed that the provider listened and acted on feedback from the PPG, for example adjustments had been made to the practice telephone system based on patient feedback. The provider had identified that recruitment of additional PPG members was required in order to better represent the diverse community.	

Continuous improvement and innovation

There was 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: Significant events were used to make improvements. The provider told us that learning from significant events were shared with staff and staff we spoke with confirmed this. We saw evidence that one meeting for administrative staff had taken place in the last 12 months. Staff told us that clinical governance meetings took place; however these were not formally recorded. The provider told us as part of their action plan that they would restart regular staff meetings. We saw evidence that information was shared with staff via email, for example updates about the phone systems and details on staff responsibilities.	

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.
- **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.