

Care Quality Commission

Inspection Evidence Table

Dr K Anantha-Reddy's Practice (1-559610416)

Inspection date: 19 October 2022

Date of data download: 11 October 2022

Overall rating: Requires improvement

At this inspection, which was carried out between 17 and 19 October 2022, we rated the practice as requires improvement. This was because we identified concerns relating to the provision of safe, effective and well-led services. Please see below for detailed findings.

Safe

Rating: Inadequate

At this inspection, we rated the practice as inadequate for providing safe services because:

- We found issues with the monitoring of patients prescribed some high risk medicines.
- We found that the system for managing and acting on Medicines and Healthcare Products Regulatory Agency (MHRA) alerts was not always effective.
- We identified issues with the monitoring and management of the over-usage of medicines.
- We identified some gaps in relation to staff member immunisations. We found that the staff immunisation programme was not implemented as per UK Health Security Agency guidance.
- We found gaps in staff training records in relation to safeguarding, infection prevention and control and information governance training. We did not see evidence that the practice nurse had completed safeguarding adults and children training. We found that non-clinical staff had not completed safeguarding children training to the appropriate level.
- We found that the system for infection prevention and control (IPC) was not always effective.
- We found that the system for the storage of vaccinations was not consistent with Public Health England guidance.
- We found that the practice did not have an effective process for the monitoring of fridge temperatures.
- We found that the process for monitoring emergency medicines was not sufficient as we found out of date medicines and supplies.
- We identified that the system for monitoring two week wait referrals was not effective.

The practice was therefore rated as inadequate for providing safe services.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
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.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had a vulnerable adults policy which identified the lead for safeguarding. The practice had a child protection protocol which did not have up to date details for the safeguarding leads at the practice. The practice policies did not contain information about the monitoring of potential patients at risk of Female Genital Mutilation (FGM) and the practice did not have a separate FGM policy. Clinical staff we spoke with told us about the processes for management of patients at risk and escalation to the safeguarding lead. Staff members we spoke with were familiar with the practice's safeguarding policies and were confident in the method of escalation if a safeguarding incident arose. The practice held adult and children safeguarding registers which were reviewed and updated on a quarterly basis. The practice discussed safeguarding concerns at weekly clinical meetings. The practice told us that it discussed safeguarding cases where appropriate with the local authority safeguarding lead. The practice added safeguarding codes to the clinical records system to identify patients with safeguarding concerns. We found that some clinical and non-clinical staff did not have up to date safeguarding adults and children training. The practice nurse had outstanding training and one of the non-clinical members of staff and one of the GP partners had not completed up to date training. The practice told us that the practice nurse had completed safeguarding adults and children training to the appropriate level but we did not see evidence of this. The practice assured us that the non-clinical member of staff and GP partner had completed the updated safeguarding adults and children training following our site visit. We found that members of non-clinical staff had not completed safeguarding children training to the appropriate level which did not comply with The Royal College of Nursing intercollegiate guidance on safeguarding children. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We reviewed staff files for two clinical and two non-clinical members of staff. We found that staff files were mostly kept up to date. We identified that the file of the practice nurse did not contain a certificate regarding their nursing practitioner qualification. The practice forwarded us this certificate after our site visit. We identified some gaps in relation to staff member immunisations and these were not in line with UK Health Security Agency (UKHSA) guidance. The practice told us that it had not checked the immunisations status for newer members of non-clinical staff. The two non-clinical members of staff we reviewed started working at the practice in August 2021 and June 2022 respectively. We noted that there were incomplete immunisation records for the phlebotomist and practice nurse. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 22 June 2022	Partial
There was a fire procedure.	Y
Date of fire risk assessment: 26 September 2022 Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Health and safety and fire risk assessments were completed by external companies and June and September 2022 respectively. We saw evidence that the practice had completed or was in the progress of completing actions identified in the fire risk assessment report. We did not have confirmation from the practice that actions identified in the health and safety risk assessment had been completed or were in progress. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 14 January 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	

- We found that there were systems in place for managing infection prevention and control (IPC). The practice had an infection control policy and designated clinical and non-clinical leads. The infection control policy did not refer to the requirement to conduct IPC audits. The practice completed IPC inspection checklists on an annual basis and the latest audit was completed in January 2022.
- We saw some gaps in the training records of one member of clinical and one member of non-clinical staff in relation to completion of updated IPC training. The practice informed us following our inspection that these staff members had now completed this training.
- During our site visit, we noted that the practice kept all cleaning products in a locked cupboard. We observed some cleaning products in an unlocked cupboard under the sink in the staff kitchen area that was accessible to patients who passed this cupboard when accessing the nurse's room.
- During our site visit we observed a sharps bin that had not been signed and dated on assembly.
- We saw evidence of a legionella risk assessment and legionella water sample report that was carried out by an external company on 22 June 2022. Legionella bacteria can cause a pneumonia-type illness called Legionnaire's disease. We did not have confirmation from the practice that actions identified in this report had been completed or were in progress.

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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
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.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Staff we spoke with were aware of what action to take in the event of a medical emergency and were aware of how to raise an alarm. The practice had a medical emergency and resuscitation policy that was available for staff to view on the shared drive. We saw evidence that staff, both clinical and non-clinical, had completed basic life support and sepsis awareness training. 	

Information to deliver safe care and treatment

Staff had not have the information they needed to deliver safe care and treatment, however improvements were required.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. ¹	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• We found that most staff had completed the appropriate information governance training. We found that one GP partner had not completed update training. The practice assured us after our inspection that this now had been completed. We observed that clinical data was kept securely.• The practice had a process for the summarising of patient notes and had a member of staff who was responsible for this task. The practice was in the process of training another member of staff to provide cover for the summarising of notes when the main member of staff was on annual leave. We did not see evidence of the number of outstanding patient notes to be summarised.• At the time of our inspection, we were not assured that the practice had an effective process for monitoring two week wait referrals. The practice told us that they had a dedicated member of staff who monitored all referrals. The practice stated that it had safety netting mechanisms and that all two week wait referrals were logged in a folder and reviewed weekly to check if a patient had been seen by the hospital. During our site visit, we reviewed the folder which was used to monitor two week wait referrals and saw some gaps where the practice had not completed whether a patient had attended an appointment.• The practice had an effective system for the management of workflow and test results.	

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation

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

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.96	0.59	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)	9.3%	8.8%	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)	4.61	5.57	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	91.8‰	57.7‰	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)	1.13	0.46	0.59	Tending towards variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	6.5‰	4.8‰	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.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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.	N/A
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	Partial
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.	Y

Medicines management	Y/N/Partial
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	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Partial
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
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.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
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.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Partial
<p data-bbox="57 1113 1541 1169">Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> <li data-bbox="108 1191 1541 1449">• During our site visit we found that the process for monitoring emergency medicines was not sufficient as we found out of date medicines and supplies. We found out of date dexamethasone (a medicine used to treat a wide range of health conditions including severe skin conditions, severe allergies, nausea and vomiting, croup, inflammation in the eye and autoimmune conditions) which was labelled to be used until October 2022, scissors that had expired in July 2022 and a box of sterile gloves that had expired in December 2021. The practice informed us that these items would be removed from the emergency medicines box. <li data-bbox="108 1482 1541 1785">• During our site visit, we reviewed the practice's processes for checking fridge temperatures and the handwritten log kept at the practice. The practice told us that it was its policy to check fridge temperatures twice a day to ensure that temperatures were within range. The practice manager checked fridge temperatures when the nurse was not working at the practice. We observed that in August 2022, when the practice manager was on annual leave, there were some days when the fridge temperatures were not checked by another member of staff. The practice's data logger in the fridge was not working when we attended on site. The practice told us that they would check this data logger to ensure that it was working. <li data-bbox="108 1818 1541 2002">• The practice had a cold chain policy. The practice had one fridge for the storage of vaccines and we observed during our site visit that the fridge was over-stocked, with insufficient gaps around the vaccines for air to circulate. This was not consistent with Public Health England green book guidance about the ordering, storing and handling of vaccines or the practice's cold chain policy. The practice told us that it had received the flu vaccine which had led to the fridge becoming full. 	

Medicines management	Y/N/Partial
<p>We found that there was no system in place to manage times when more vaccines were received to ensure that correct storage was maintained.</p> <ul style="list-style-type: none"> • Whist monitoring was completed appropriately for some high risk medicines (methotrexate, an immunosuppressant medicine used to slow down the body's immune system and reduce inflammation), there were some issues identified for other high risk medicines. In particular: • We found that patients prescribed azathioprine (a type of immunosuppressant used to calm or control the body's immune system and used to treat inflammatory conditions including rheumatoid arthritis, Crohn's disease, ulcerative colitis, severe inflammation of the liver, skin or arteries and some blood disorders) had not always had the appropriate monitoring. We identified eight patients in our clinical searches who were prescribed azathioprine and two of these patients had not had the required monitoring. We did not see evidence that shared care agreements were in place. The practice told us that the patients identified in our clinical searches had completed their blood tests but that this was sometimes not coded properly. • We found that patients prescribed angiotensin converting enzyme (ACE) inhibitors and angiotensin II reception blockers (ARBs) (medicines mainly used in the treatment of high blood pressure and heart failure) had not always had the appropriate monitoring. We reviewed the records of five patients prescribed these medicines identified through our standardised searches. We saw that four patients had been advised to attend for monitoring, however no recent blood test monitoring had been completed prior to the prescribing of this medicine. One of the patients we reviewed was a newly registered patient, however their medicine had been issued and no recent blood test monitoring had been reviewed prior to the prescribing of this medicine. Following the inspection, the practice confirmed that all patients had been booked for monitoring where this was overdue. • We reviewed patients prescribed benzodiazepines (medicines indicated for the short term relief of anxiety that is severe, disabling or causing the patient unacceptable distress) and Z-drugs (medicines indicated for the short term management of insomnia in adults in situations where the insomnia is debilitating or causing severe distress for the patient). We identified 65 patients in our clinical searches who were prescribed over 10 prescriptions for benzodiazepines or Z-drugs. We reviewed five of these patients and found that clinical records did not consistently detail that patients were informed of the risk of addiction or document attempts to wean patients off benzodiazepines and Z-drugs. We could not be assured that the practice approach was consistent and that there were effective systems and processes in place for the monitoring of over usage of these medicines. At our site visit, the practice showed us some examples of clinical records where consultations had been completed which detailed that some patients had been counselled about the risks of these medicines, that discussions about wearing off had taken place and that separate medication reviews had been coded on the same day, however, the majority of these discussions not taken place recently and we could not be that the practice approach was consistent and that there were robust systems and processes in place for the monitoring of over-usage of these medicines. • We noted that the prescribing data from NHS England identified that the practice's prescribing of hypnotics was higher than local and national averages. The practice had not taken action to review and address the cause of higher than average levels of prescribing hypnotic medicines. The practice told us that the Primary Care Network (PCN) pharmacist would conduct an audit into this prescribing but could not give us a date for this. The practice told us that it was situated in a 	

Medicines management	Y/N/Partial
deprived area and that it would raise with patients if it was concerned about addiction and would refer patients to the appropriate organisations.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong, however improvements were required.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
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.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months: January 2022 to September 2022	3
Number of events that required action:	3
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice told us that it had a significant events policy, however we did not see evidence of this. The practice told us that all significant events were reported to the practice manager and were entered in a book in the reception area and the practice completed significant event forms which were saved on the shared drive. We saw evidence of the significant events analysis spreadsheet which recorded incidents from January 2022 to September 2022. This spreadsheet was kept by the practice on its shared drive which included the date of event, a summary of the event, action taken and learning identified. The spreadsheet did not identify any clinical significant events and did not provide detail about when the matter was discussed at practice and clinical meetings. The practice told us that significant events and learning were discussed at practice meetings which were held on a monthly basis and at clinical meetings which were held on a weekly basis and that significant events was a regular agenda item for these meetings. Minutes from these meetings were available on the shared drive and would be provided to staff who were not in attendance. At the start of each meeting, the practice would discuss the minutes from the previous meeting. Staff members we spoke with were able to explain how they would escalate incidents and significant events to management. Staff reported that not all incidents they reported were treated as significant events. 	

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

Event	Specific action taken
Patient late for appointment and became aggressive and rude to staff.	The panic button was pressed and police were informed. The situation was de-escalated and the patient attended an appointment the next week.
Patient report about staff attitude	The practice spoke with staff and concluded that the staff behaviour was appropriate. The learning identified was that staff should be careful about how patients perceive the way they speak and their body language.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Partial
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We found that the practice did not have an effective system in place for receiving and actioning Medicine and Healthcare Products Regulatory Agency (MHRA) alerts. In particular, we identified 52 patients in our clinical searches who were prescribed sodium-glucose co-transporter (SGLT-2) inhibitors (medicine used to treat type 2 diabetes) which was the subject of a MHRA alert in November 2019. We reviewed five of these patients and found that three patient records did not have a documented risk of Fournier's gangrene and two had a note of their clinical records which stated that risks had been discussed, but there was no mention of the specific risk of Fournier's gangrene. Fournier's gangrene is an acute necrotic infection of the scrotum, penis or perineum. The practice told us following our site visit that this alert had now been discussed at its clinical meeting and appropriate changes to practice implemented. The practice also confirmed that following the inspection, it had discussed the risk of this side effect with all relevant patients so they could take an informed decision about taking this medicine. The practice had a dissemination of drug alerts policy and the practice told us that MHRA alerts were received by the practice manager and lead GP by email. Clinical alerts and guidance were passed to the PCN pharmacist who shared the information with clinicals at the practice and actioned the alert where appropriate. The practice told us that alerts were discussed at clinical meetings, however alerts were raised on an ad hoc basis and was not a standing agenda item. The practice saved minutes from clinical meetings on the shared drive but did not have a system for staff to sign to confirm that they had read the minutes of meetings. We did not see meetings from the clinical meetings which evidenced that MHRA alerts had been discussed. We did not see evidence of the practice's log of patient safety alerts. The practice told us that all alerts were kept in a folder on its shared drive. 	

Effective

Rating: Requires improvement

At this inspection, we rated the practice as requires improvement for providing effective services because:

- We identified issues with the monitoring and management of long-term conditions, in particular in relation to patients with chronic kidney disease (CKD) stages four or five, patients with hypothyroidism, patients with acute exacerbation of asthma and potential missed diagnosis of diabetes.
- The practice had not met the minimum 90% uptake for all of the childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity). The practice was working towards improving uptake and reducing barriers to childhood immunisations.
- The practice's uptake for cervical screening was below the 80% coverage target for the national screening programme. The practice was working towards improving uptake and reducing barriers to cervical screening.

The practice was therefore rated as requires improvement for providing effective services.

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. ³	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y

Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had a process for communicating guidance to keep clinicians up to date with current evidence-based guidelines. The practice told us that guidance was communicated at its weekly clinical meetings. Monthly meetings were held with the PCN where updates on local guidelines were discussed and these were disseminated at the practice's clinical meetings where appropriate. • During the Covid-19 pandemic, the practice had a triage system for patients who presented with acute symptoms. The practice had ensured that all patients in high risk groups were alerted and had up to date immunisations. The practice had visited patients at risk where appropriate to check on their well-being. 	

Effective care for the practice population

Findings

- The practice offered a range of general medical services and held the following clinics on a regular basis by appointment:
 - Maternity post-natal
 - Maternity new booking
 - Childhood immunisations
 - Cervical screening
 - Hypertension clinic
 - Diabetic clinic
 - Coronary heart disease
 - Eight week baby checks
 - Holiday injections/ advice
 - Family planning
 - Well person
 - Asthma clinic
 - Blood testing
- The practice offered health checks for new patients, patients over the age of 75 and for patients every three years unless they had been seen for another reason. The practice signposted and referred patients to other services offered by Hillingdon Clinical Commissioning Group (CCG), including chiropody, dietetics, physiotherapy, counselling and diabetes clinics.

Management of people with long term conditions

Findings

We found that monitoring of patients with chronic kidney disease (CKD) stages four or five had not always been completed appropriately within the specified timeframes. Our clinical searches indicated that six patients (out of a total of 21 patients with CKD stages four or five) may not have had the required blood pressure and urea and electrolyte (U&E) monitoring in the last nine months. We reviewed five of these patients and found issues with three of the patients. For two of these patients, their last blood pressure readings were not within the normal range and we did not see any recent U&E results or recent blood pressure readings for the patients. The practice told us that there were issues with compliance in relation to one patient and that the other patient was believed to be abroad. The third patient we reviewed was suspected to be a 'ghost patient' (for example, a patient who had left the practice) and the practice told us that it believed that this patient was abroad. The practice told us at our site visit that it had contacted the dialysis CENTRE for patients under secondary care and was in the process of obtaining blood results for these patients. The practice informed us that administrative staff had been informed regarding the appropriate coding of results.

- We found that monitoring of patients with hypothyroidism had not always been completed appropriately within the specified timeframes. Our searches indicated 15 patients (out of a total of 156 patients with hypothyroidism) who had not had thyroid function testing for more than 18 months. We reviewed five of these patients and found that the patients were issued with regular prescriptions despite no blood tests having been completed. One of the five patients had an abnormal result when they last had blood test monitoring and in these circumstances, they should have had their dosage reviewed and repeat monitoring completed after three months. All five patients were reviewed had not had medication reviews within the last 12 months. The practice had identified that blood test monitoring was overdue but this had not been completed. We noted that the practice had requested blood testing for three of the patients after notification of this inspection. The practice told us at our site visit that it had reviewed the patients identified in our clinical searches and had issued blood test forms and had contacted patients.
- We found that monitoring of patients with acute exacerbation of asthma was not always completed appropriately. We identified 253 patients in our clinical searches on the asthma register and 10 patients with asthma who had been prescribed two or more courses of rescue steroids in the past 12 months. We reviewed five of these patients and found that: one patient had not had a recent asthma review and had not been provided with a steroid warning card; one patient had not had an assessment within the specified timeframe following issue of rescue steroids and had not been provided with a steroid warning card and their treatment had not been stepped up or adjusted following the acute exacerbation of their asthma to improve control of their symptoms; one patient had not had an assessment within the specified timeframe following issue of rescue steroids, had not had a recent asthma review and had not had their treatment stepped up or adjusted following the acute exacerbation of their asthma to improve control of their symptoms; one patient had not had an assessment within the specified timeframe following issue of rescue steroids, had not had a recent asthma review, had not been provided with a steroid warning card and had not had their treatment stepped up or adjusted following the acute exacerbation of their asthma; and one patient who had not had a follow up conducted to check their response to treatment within one week of the acute exacerbation of their asthma and their treatment had not been stepped up or adjusted following the acute exacerbation of their asthma. The practice confirmed that patients had been issued with steroid cards following the inspection as appropriate.

- We found that the systems and processes in place to monitor and review patients with previously recorded raised HbA1c on two or more occasions did not always comply with national clinical guidelines. We identified five patients in our clinical searches as having a potential missed diagnosis of diabetes. We reviewed these five patients and found that one patient had not been followed up or coded as prediabetic as appropriate and one patient had not been coded as diabetic appropriately. The practice told us at our site visit, (and provided evidence following the inspection), to show that it had reviewed the patients identified in the clinical searches and that it did not diagnose patients with diabetes until a confirmatory blood test had been received and that it allowed patients three to six months to address their lifestyle.
- We did not identify any issues with the management of patients with diabetic retinopathy (a complication of diabetes caused by high blood sugar levels damaging the back of the eye), however, some medication reviews for the patients we reviewed were not completed in appropriate detail.
- The practice told us that it met internally regularly to discuss long-term conditions performance and met with the PCN on a monthly basis to discuss this. The practice manager had oversight of long-term conditions searches and patients were sent text messages via a messaging system and telephoned patients where they did not have a mobile telephone number.

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)	55	62	88.7%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	60	79	75.9%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	64	79	81.0%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	64	79	81.0%	Below 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)	11	13	84.6%	Below 90% minimum
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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

- The practice had not met the minimum 90% uptake for all of the childhood immunisation uptake indicators and was below 80% in one of the indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity for all of the childhood uptake indicators). We saw an upward trend in the uptake of immunisations in three of the indicators since our last inspection.
- The practice was working to improve the uptake of childhood immunisations. The practice told us that since January 2021, when things returned to normal following the Covid-19 pandemic, it used the list received from the child health information service (CHIS) and ran its own searches through the clinical records system so that children due to have immunisations could be booked. The practice received a list from CHIS every week which was actioned by the practice manager who called and booked children in for their immunisations. The practice sent a total of two text messages to parents or guardians and if they did not book an appointment for immunisations, the practice nurse was sent a task to call and explain the process to parents or guardians to encourage their attendance. The practice telephoned parents on their landline if it did not hold a mobile number for the parent or guardian, or sent a compliment slip to invite them to book an appointment if no telephone numbers were held for patients. The practice sent a letter to parents or guardians if they had not booked an appointment after two text message invitations.
- The practice recorded immunisations completed on its clinical records system and in a patient's red book. The practice ensured that copies of the red book were taken and vaccines updated on its clinical records system when registering new children.
- The practice told us that there was some reluctance from parents or guardians to attend with their child for immunisations due to Covid-19. The practice told us that it sought to reassure patients that arrangements were in place to decrease the risk of infection. The practice told us that from September 2022, the practice nurse was attempting to actively increase the immunisation uptake (they started in September 2022) but that this had been slowed by the polio booster programme and the start of flu vaccinations. The practice told us that it was looking to increase the number of appointments for the nurse in the future.

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	65.6%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	18.6%	48.9%	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)	54.8%	57.1%	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)	54.5%	56.0%	55.4%	No statistical variation

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

Any additional evidence or comments
<ul style="list-style-type: none"> The practice was working to improve cervical screening uptake and we saw a slight improvement in uptake since our last inspection. The practice told us that since October 2020, it had devised a new process where the practice manager ran a search and provided a list to reception staff of patients who were due for cervical screening. The reception staff sent a text message invite to patients and repeated this process every four months. The practice sent a total of two text messages to patients and if they had not booked an appointment, a task was sent to the practice nurse to call the patient and explain about the importance of cervical screening to encourage their attendance. The practice sent a letter to patients if they continued to decline cervical screening. The practice called patients on their landlines if a mobile number was not held for them and a compliment slip to invite them to book an appointment if not telephone numbers were held. The practice downloaded lists of patients for cervical screening from the NHS system that held information relating to cervical screening. The practice told us that since January 2020, the local confederation had worked with practices in the locality to increase their uptake for cervical screening. The practice sent the confederation lists of patients and they were then invited to attend for cervical screening at a hub centre. This was then recorded on the practice's clinical system and the results were sent to the practice. The practice nurse recorded appointments in a cervical screening book in the nurses room and results, when received, were entered on the clinical system and entered in the cervical screening book. If a patient's results were normal, a letter would be sent by the administrative staff to a patient. If results were abnormal or if anything needed to be discussed with a patient, the practice nurse would discuss this with the patient and a letter would be sent to them for any further follow up or referral. The practice coded patients who required colposcopy (a test to look closely at the

cervix) and the nurse or GP would contact a patient to explain the result and reassure patients. The cervical screening book entries were checked on a monthly basis to check that results were received and the practice informed Cervical Screening London if they had not.

- The practice told us that some patients were reluctant to attend for cervical screening due to Covid-19 and since January 2022 it had focused on improving its booking system and catch up on cervical screening. The practice planned to increase uptake from September 2022 by opportunistically offering cervical screening to patients when they attended for nursing appointments. The practice planned to run searches every two months moving forwards instead of every four months.
- The practice told us that some cohorts of patients were reluctant to attend for cervical screening. The practice used translation services where appropriate and had information about cervical screening in multiple languages available at the practice for patients to refer to. The practice had a television screening in the waiting area where it displayed information about cervical screening and childhood immunisations. The practice told us that it planned to work with Cancer Care UK to ask for advice on how to increase uptake of cervical screening and spoke with other practices in the PCN to share good practice.

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.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

- Asthma prevalence audit (July 2021 to January 2022)
The practice conducted a search to identify patients who had asthma diagnoses and ensured that patients were correctly coded.
Following the audit, the practice added a further 203 patients to the asthma register. The practice noted that it was behind the national average prevalence for asthma but planned to continue to monitor by conducting audits and increasing awareness amongst the practice population and screen patients opportunistically.
Feedback was provided to the practice to complete a full audit cycle to demonstrate the impact of the learning.
- Direct-acting oral anticoagulants (DOACs) audit (undated)

The practice created a search with all patients on DOACs and calculated their creatinine clearance from their latest creatinine results to determine if they were on the correct dose, how often they should be monitored, and book patients for blood tests if they were due.

The practice noted that there was a total of 50 patients prescribed DOACs and that 10 of these patients had not had their creatinine clearance calculated. Five patients over the age of 75 had not had their creatinine blood test checked and seven patients under the age of 75 with creatinine clearance below 60 had not had their creatinine checked recently. The practice repeated the audit after four weeks and all patients had had their creatinine clearance calculated, apart from one patient where results were pending. Eight patients were due for their blood tests which would be booked.

- Non-steroidal anti-inflammatory drugs audit (NSAIDs) (Cycle one: June 2021; cycle two: December 2021)

The practice conducted a search on its clinical system to identify patients on NSAIDs without a gastro-protective medicine.

In cycle one, the practice identified 50 out of 126 patients and in cycle two, it identified nine out of 127 patients.

The practice concluded that this demonstrated an improvement in gastro-intestinal protection for vulnerable patients on NSAIDs and planned to repeat the audit every six months.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
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.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice encouraged staff to undertake training. Staff members told us that they were sometimes given protected time for training, with some staff members completing training in their own time. 	

- The practice manager had oversight of staff training and raised training the practice meetings to encourage staff to complete modules. The practice manager sent emails to staff where training was overdue and checked records every two months. We found that some staff training was not up to date. We saw that the practice nurse had not completed all mandatory training, including safeguarding adults and children training. The practice assured us that this had been completed but we did not see evidence of this when we inspected. We found that non-clinical members of staff had not completed safeguarding children training to the appropriate level. We saw that one member of non-clinical staff and one GP had not completed updated safeguarding adults and children training. We saw that one non-clinical and one clinical member of staff had not completed updated IPC training. We saw that one GP had not completed updated information governance training. The practice told us following our inspection that this was now up to date.
- The practice conducted annual appraisals with staff members and identified development needs during this process. At the time of inspection, the practice was due to complete its annual appraisals for 2022. The practice supported staff in developing their skills and areas of interest. The practice told us that it had supported one member of non-clinical staff in completing phlebotomy training recently.

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.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice acted on communications from external services to maintain continuity of care. 	

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.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice told us that the PCN social prescriber had left at the start of 2022 and that the PCN was in the process of recruiting for a replacement. The practice informed us that it referred patients over the age of 18 to the care connection team (CCT) if appropriate and held meetings twice a week with the CCT. The practice referred patients for assistance by signposting to other services, including the PCN physiotherapist and asthma, diabetes and COPD clinics which were run by the PCN clinical pharmacist. 	

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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Partial
Explanation of any answers and additional evidence <ul style="list-style-type: none"> There was a process in place for DNACPR decisions, which were documented on the clinical system. The practice told us that it would review its DNACPR coding as our clinical searches detected one patient with a DNACPR decision in place, when the practice told us at our site visit that there were 20 patients with DNACPR decisions. The practice told us that it would review DNACPR decisions for patients where a review had not been completed annually. 	

Responsive

Rating: Not rated

Access to the service

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.

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• The practice opening hours were 8:30am to 6:30pm Monday to Friday. The practice was closed on weekends and bank holidays. The practice used a local doctor co-operative deputising service for out of hours emergencies and directed patients to call 111 out of hours.• Patients were able to access appointments by telephoning the practice at 8:30am for morning appointments and 2:00pm for afternoon appointments. The practice referred patients to the local hub if it was unable to book a patient into an appointment at the practice. The practice received requests for home visits and these were conducted after morning surgery or if a patient was on the care connection team list, the practice would liaise with them so that they could visit the patient.• The practice had a hearing loop in the reception area and had posters on the premises in the reception area and consultation room providing information about translation services. The practice had a number of staff who were able to speak different languages. The practice had a wheelchair for patients to use. The practice had increased the amount of emergency same day appointments in response to patient feedback.	

Well-led

Rating: Requires improvement

At this inspection, we rated the practice as requires improvement for providing well-led services because:

- The practice was not always managing prescribing and associated monitoring in line with guidelines.
- The practice was not always appropriately managing patients with long-term conditions.
- The practice did not always maintain an accurate record in respect of each patient. Medication reviews were not always completed in detail, including that monitoring was up to date or requested and that any relevant safety information or advice had been addressed.
- The practice system for managing and acting on Medicine and Healthcare Products Regulatory Agency alerts was not always effective.
- The practice recruitment systems were not always effective, in particular in relation to staff immunisations.
- The practice systems for ensuring that staff training was kept up to date and to the right level were not always effective.
- The practice did not have an effective system for monitoring of two week wait referrals.
- The system for monitoring of emergency medicines and storage of vaccinations was not effective.

Therefore we have rated the practice as requires improvement for providing well-led services.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y

Explanation of any answers and additional evidence:

- The practice told us that it had identified challenges in relation to the recruitment of staff. In particular, the practice told us that since 2020, there had been turnover of staff and the practice reported that staff had left and it had recruited new staff. The practice told us that it had been actively trying to recruit a female GP for a long period of time and that from November 2022 it had secured a long term female locum for one day per week. The practice told us that during the Covid-19 pandemic, it had had some long term staff sickness and had looked to arrange long term cover and had arranged locum nurse staffing, broader PCN coverage and had arranged for cervical screening to be conducted at extended access hubs. The practice had employed a new practice nurse practitioner in September 2022 who was concentrating on childhood immunisations and cervical screening. The practice was in discussions with the practice nurse to increase their hours. The practice utilised the services of a PCN pharmacist who was in the process of completing prescribing training and was being monitored by a GP partner.

- The practice told us that it would like in the future to recruit another GP partner so that one of the other partners could have more time to dedicate to policies and procedures. At present, this GP partner dedicated two hours per week to administrative tasks. The practice was currently recruiting for a GP partner but had not yet been successful.
- The practice had plans to refurbish its premises and increase consultation rooms.

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.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had a vision statement which detailed that its purpose was to work together to provide the best possible care for patients. The practice aimed to provide holistic, evidence based care with a sympathetic and friendly approach in order to optimise the health and wellbeing of the practice population. The practice told us that it was working in conjunction with the PCN and was using the searches provided by the PCN to provide better care for patients. • Staff we spoke with were fully conversant with the values and evidenced their understanding and role in achieving this. 	

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.	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 had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice told us that it encouraged continuous learning and innovation and routinely asked staff members for feedback and ideas at practice meetings. The practice had an open culture which was free from discrimination, for both staff and patients. We received feedback in staff interviews that suggested that there was a positive relationship between staff and management, with staff reporting that they enjoyed working at the practice. 	

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

Source	Feedback
Staff interviews	All the staff we interviewed spoke positively about their employment at the practice. Staff members told us that the work was sometimes stressful, but that they felt that management was supportive and that they felt comfortable and confident in raising issues with them.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence:	

- The practice had a governance framework in place, however, it was not always effectively managing risks. These included the risks associated with the monitoring of patients on high risk medicines, actioning of patient safety alerts, ensuring that staff training was up to date and to the correct level, ensuring staff immunisations were in line with guidance, having an effective system for monitoring of two week wait referrals, monitoring of emergency medicines and vaccinations, ensuring an effective system for storage of vaccinations and management of long-term conditions.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • We found that the practice was not always keeping accurate or comprehensive clinical records. In particular, medication reviews were not always completed in detail in the medical records, including not displaying that all monitoring was up to date or requested and that any relevant safety information or advice had been addressed. 	

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.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y

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

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.	Y
The practice had an active Patient Participation Group.	Partial
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice told us that it had historically met with the Patient Participation Group (PPG) on an annual basis. The practice told us that it had attempted to contact members of the PPG but had been unable to recently arrange a meeting at a mutually convenient time. The last meeting was held in 2019. The practice informed us that due to the constraints of space at the practice, it would be difficult to hold a meeting in person with the PPG. The practice told us that it had been in contact with PPG members. For example, it had worked with a member of the Muslim community to encourage discussion at the local Mosque regarding childhood immunisations and cervical screening to promote uptake. 	

Feedback from Patient Participation Group.

Feedback

We spoke with members of the PPG who told us that they had not met as a group since before the Covid-19 pandemic. They informed us that the practice was open and honest in its interactions with the group previously and with patients. We received feedback that the practice could be improved by refurbishment and extension of the premises and that the appointments offered by the practice could sometimes be difficult to book. They told us that the practice was making improvements to improve the care offered to patients and that staff were courteous and helpful.

We also spoke with a care home manager from a group of care homes that the practice provided services to. They told us that the majority of their residents were registered with the practice. They informed us that the practice and care homes management had built a good relationship based on trust. They told us that the practice was very responsive and that the practice offered a very high level of care to residents. They informed us that the practice had been responsive and had provided a good service throughout the Covid-19 pandemic. They told us that the practice dealt with residents with a high level of compassion.

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.	Partial
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">Staff at the practice were encouraged and supported to undertake learning. Staff members told us that management was supportive of their development needs and aspirations. However, we found that there were some gaps in training records in relation to safeguarding adults and children, IPC and information governance training. We also found that non-clinical staff had not received safeguarding children training to the appropriate level.The practice had a culture of sharing learning from significant events and complaints and made improvements as a result of lessons learned.	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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