Care Quality Commission

Inspection Evidence Table

Dr Abdul-Kader Vania (1-493977210)

Inspection date: 15 July 2021

Date of data download: 07 July 2021

Overall rating: Inadequate

This practice was rated as inadequate at the Care Quality Commission (CQC) inspection in April 2021, and was placed in special measures. Following the inspection, the practice was issued with four warning notices in relation to breaches of regulation 12 (safe care and treatment); regulation 13 (safeguarding service users from abuse and improper treatment); regulation 17 (good governance); and regulation 18 (staffing).

This inspection was undertaken in July 2021 to review compliance with the warning notices that were issued and had to be met by the end of June 2021. The inspection was not rated and therefore the ratings remain unchanged. The practice will receive a further inspection to review progress in all areas in six months' time, and that inspection will be rated.

Safe

This inspection was not rated and therefore the inadequate rating from our inspection in April 2021 remains unchanged.

Safety systems and processes

The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	partial
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
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.	partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y

Safeguarding	Y/N/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.	partial

Explanation of any answers and additional evidence:

- Remote access to clinical records at our previous inspection in April 2021, identified that it was unclear if patients with coded safeguarding concerns were still active or resolved. At this inspection in July 2021, we found that child safeguarding records had been reviewed, but with work still to commence to review adult safeguarding records. We undertook a further remote patients' records search that identified more work was required to make sure safeguarding cases were reviewed regularly and updated, and contained all relevant information. However, we observed that progress was being made.
- At the previous inspection in April 2021, alerts were not being recorded on patient records to flag safeguarding concerns. This meant that clinicians would not be aware of the safeguarding issues when they accessed the home screen of the patient's records. At this inspection in July 2021, we reviewed records via remote access and found that alerts had been introduced onto children's records, but our review of adult safeguarding demonstrated that this process was not complete. Further work was required to make safeguarding records fully accurate and in alignment with practice safeguarding registers.
- We were provided with conflicting information about the safeguarding register at our previous inspection in April 2021, but no evidence was provided to demonstrate this was in active use. At our inspection in July 2021, we found that work was in progress to produce an accurate register. All children who had been previously identified for safeguarding were being reviewed to ensure that coding had been recorded correctly, and any follow-up that might be necessary was completed. The practice was aware that they needed to then undertake a similar review for adult patients.
- Following our previous inspection in April 2021, the practice had engaged with the Clinical Commissioning Group's (CCG) safeguarding lead doctor to help them to review their approach and to achieve better outcomes in respect of safeguarding. The practice had embarked on completing a CCG quality markers tool for child and adult safeguarding to ensure they were fully compliant with all aspects of safeguarding in primary care. They acknowledged this would take a while to complete but they demonstrated a commitment in working towards achieving this. We were informed that weekly meetings were in place with the CCG safeguarding lead doctor to facilitate this.
- At our previous inspection in April 2021 we had concerns that child and adult safeguarding policies required updates and further customisation to reflect the arrangements within the practice and locally. The practice provided us with policies in July 2021 and we saw these had been updated and were now of a good standard. The child safeguarding policy referenced that reception and administrative staff should complete Level 1 training. Intercollegiate guidance states that the minimum level required for non-clinical staff who within their role have contact (however small) with children and young people, parents/carers or adults who may pose a risk to children, should complete Level 2 training. However, we saw that reception/administrative staff had actually completed level 2 training, and therefore the policy just required a slight amendment.
- The practice did not have any safeguarding or multi-disciplinary meetings in place at the time of our inspection in April 2021 to enable ongoing discussions on vulnerable children and adults. We were informed at our inspection in July 2021 that this was being progressed and the practice hoped to have a meeting was booked for August with the GPs and health visitor. The practice were also hoping to engage the midwife, social worker and school nurse in these meetings.

Safeguarding	Y/N/Partial
• Staff induction documentation viewed in April 2021 did not reference safeguarding. This had been corrected by the time of our inspection in July 2021; this ensured that new starters were provided with information on what action to take regarding any safeguarding concerns. • At the inspection in April 2021, we observed that child safeguarding training evidence was incomplete or had not always been undertaken at the appropriate level. This included the GP safeguarding lead for whom we were only provided with evidence of level one online training, rather than the required level three child safeguarding training, and one locum GP's personnel file had no evidence of having completed any safeguarding training. At our inspection in July 2021, we observed that most staff and locums were up to date with recommended safeguarding training requirements. The lead GP had attended part one of a CCG organised event, a virtual summer safeguarding children's GP forum, in May 2021. They had been unable to complete part two due to leave but we were informed this would be completed during July 2021. Attendance at both events still fell short of the required 16 hours level 3 training required over a three year period for practice safeguarding leads. We observed the lead GP had completed level one adult safeguarding training and this was due to expire two days after our inspection.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	partial
There were systems to ensure the registration of clinical staff (including nurses) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence: • At our previous inspection in April 2021, annual checks were not being done to ensure professional registration was maintained. At our inspection in July 2021, we observed that annual registrations were being checked with evidence printed for personnel files. • Staff vaccination records were incomplete at our inspection in April 2021. At this inspection in July 2021, we found that records had improved, however there were still some gaps to be completed (mostly for clinical staff) to comply with Department of Health guidance. • At the April 2021 inspection, pre-employment and locum recruitment checks were incomplete. In July 2021, we observed this had been greatly improved. Historic records for locums did not always contain the full information and the practice acknowledged the need for a risk assessment to cover this. A checklist had been introduced to each record to ensure all the relevant paperwork to support safe recruitment was collated. • We found DBS checks were absent or historic in some staff records at our previous inspection in April 2021. At our inspection in July 2021, DBS clearance was now in place, or had been applied for, for all staff and locums.	

Safety systems and records	Y/N/Partial
There were risk assessments for any storage of hazardous substances for example, oxygen cylinders, storage of chemicals.	Y
A fire risk assessment had been completed.	Y

Date of completion: 9 June 2021	
Actions from fire risk assessment were identified and completed.	Y

Explanation of any answers and additional evidence:

- At our previous inspection in April 2021, we found that the practice had not addressed actions following a fire risk assessment completed in May 2019 by an external contractor. Following that inspection, the practice arranged for a new fire risk assessment which was completed on 9 June and sent to the practice on 16 June 2021. This identified that the boiler service was overdue and needed to be completed by 30 June 2021. It also highlighted that emergency lighting in the upstairs corridor, highlighted as an action on the previous fire risk assessment in 2019, was due to be fitted imminently. When we visited the practice in July 2021, we observed that the upstairs emergency lighting was now in situ. The boiler service had not been completed but we were informed this was due to delays on the contractor's part and the practice hoped this would be completed by the end of the month, and if not they would source an alternate contractor.
- Work had commenced to improve the risk assessments for Control of Substances Hazardous to Health (CoSHH), but at the time of our inspection in April 2021, only four had been completed. In July 2021, we observed that work had been completed to identify all CoSHH substances held on site with storage instructions, control measures, and first aid advice in case of spillage. The risk assessment was attached to the appropriate Material Safety Data Sheets (MSDS) as recommended by the risk assessment findings.
- In April 2021, the practice was not able to provide evidence of a risk assessment in relation to the storage of their oxygen cylinder on site. At the inspection in July 2021, we saw that an appropriate risk assessment for the oxygen cylinder was now in place. Its location had also been included on the site floor plan in the foyer for fire-fighting purposes, as recommended in the actions from the recent fire risk assessment.
- We observed in April 2021 that oxygen was stored in a cupboard within reception marked 'oxygen' without appropriate signage. In July 2021, we observed that the practice had addressed this and appropriately highlighted the storage of the oxygen with a hazardous substance alert symbol as required.

Health and safety	**Y/N/Partial**
Premises/security risk assessment had been carried out. Date of last assessment: 9 June 2021	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 9 June 2021	Y

Explanation of any answers and additional evidence:

- At our previous inspection in April 2021, we found that the practice had not addressed actions following an external health and safety risk assessment completed in May 2019. Following that CQC inspection, the practice arranged for a new health and safety risk assessment which was completed on 9 June and sent to the practice on 16 June 2021. This highlighted an action to ensure that an inventory for any hazardous substances was updated to include all substances held on site and to ensure this was regularly reviewed and updated. It also stated that all employees whose activities involved hazardous substances should be provided with adequate information, instruction and training. In July 2021, the practice could demonstrate that the CoSHH register had been updated and was now accurate, and staff were aware of how to handle substances safely.

- We were provided with a generic whole site risk assessment tool at both the inspection in April 2021 and July 2021. In July 2021, we saw that the practice had started to develop a system of producing appropriate risk assessments for the site, for example, in relation to the handling of infants during the circumcision clinic. There was scope for further development, including individualised risk assessments for visual display equipment users.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 8 July 2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

- We observed that the practice had engaged support from their local infection prevention and control team for specialist input and advice following our previous inspection. An infection prevention and control nurse had undertaken an infection control compliance inspection on 2 June 2021 and provided the practice with a summary of their observations and recommendations. The practice had developed an action plan which had been updated to identify completed actions and those that were ongoing. The locum nurse identified as the lead for infection control audits was undertaking weekly documented environmental checks.
- The practice had acquired an example of a comprehensive infection control audit tool to be launched in-house shortly after our inspection.
- At the inspection in April 2021, the practice provided us with their infection control policy, which did not include some key information and had not been customised to reflect the internal arrangements at the practice. In July 2021, the practice provided us with an updated policy. This was much improved but needed to include specific requirements for high-risk procedures (for example, the circumcision clinic), reference to staff immunisations and Department of Health guidance, and adaptations required due to COVID.
- Some other policies related to infection control were provided on request, for example waste management and spillages. Work was underway to update these and to customise them to reflect the practice. No policy was available on the cleaning of medical equipment but the practice assured us they would complete this.
- The practice had agreed to participate in a CCG-led pilot to review the efficacy of cleaning services.

Risks to patients

There were mostly 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.	partial

Explanation of any answers and additional evidence:

- The inspection undertaken in April 2021 highlighted concerns about the lack of GP consulting time available. This had been improved when we inspected in July 2021 with an increase in GP locum hours for patient consultations, and the lead GP had two more sessions available in the practice having reduced other commitments. Locum nurse input remained the same, although one of the locum nurses was due to leave at the end of July 2021.
- At our previous inspection in April 2021, there was no induction pack available for locum staff in order to access essential information to ensure they were able to work safely in a practice. In July 2021, we were provided with a copy of a locum pack. This covered some essential and relevant information for locums but there was scope to expand this further to include, for example, information on reporting incidents, local prescribing guidance, and how to access practice policies.
- At our April 2021, administration/reception staff informed us they had guidelines in the form of a flow chart for any patients presenting with chest pain or anaphylaxis. We saw evidence to support this, but no information on other potential presenting emergencies including sepsis. In July 2021, the practice provided us with an updated emergency situation protocol for non-clinical staff which now included a section on sepsis and another on mental health. Whilst this was a positive development, the information on sepsis was directed at clinicians and needed to be amended into key points relevant to reception staff, accompanied by some training/internal discussion.

Information to deliver safe care and treatment

Staff mostly 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.	partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y

Explanation of any answers and additional evidence:

- At our previous inspection in April 2021, there was no failsafe system in place for cervical cytology samples. Failsafe is a back-up mechanism to ensure that all samples sent to the laboratory are recorded when sent, and also when the results have been returned. This ensures any samples sent for analysis that are not reported on, can be identified and followed up appropriately. In July

2021, we saw that the practice had introduced a failsafe system and we observed that this was working effectively. The practice had also produced a brief failsafe protocol for cervical screening since our inspection in April 2021. This did not contain reference and contact details to the pathology laboratories or local public health screening programmes to discuss any queries. The practice told us they would revise this and include this information.

- Our remote access to clinical records showed that record keeping for circumcisions was of a good standard. However, one of the ten records we reviewed did not include details of the volume of anaesthetic, one did not give details of the procedure undertaken, and one did not record that paracetamol had been provided. However, all other entries were completed in line with recommended inclusion criteria. A review of details held on the clinical system in respect of safeguarding was under review at the time of our inspection in July 2021.

Appropriate and safe use of medicines

Medicines management	Y/N/Partial
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	partial

Explanation of any answers and additional evidence:

- At the inspection in April 2021, there was no system in place for tracking prescription stationery on receipt or upon their distribution throughout the practice. At the inspection in July 2021, we observed that internal security arrangements had been strengthened. A log had been devised and we saw that this had a recorded entry for prescriptions that had been moved into a printer, however, the full stock had not been recorded. We requested a copy of the practice policy regarding prescription security but this was not provided.

Track record on safety and lessons learned and improvements made

The practice mostly 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.	partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	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

Explanation of any answers and additional evidence:

- At our inspection in April 2021, we were not assured that all events were being captured as part of the significant event process. There was limited evidence to demonstrate that learning from incidents was being shared effectively with members of the team and long-term locums. In July 2021, we saw some evidence that incidents had been reported, reviewed and actions taken to minimise occurrence. We also observed that monthly staff meetings were now in place and significant events were part of the standing agenda items. We saw that minutes included reference to learning points following an incident. We highlighted to the practice that any actions needed to be completed and recorded to evidence the outcomes achieved. We did not see any evidence of

any significant events being reported by clinician and minutes from the nurses meeting in June 2021 did not reference any significant events.

An example of a significant events recorded and actions by the practice.

Event	Specific action taken
• A patient referral had been missed – a task had been sent to the administration team from the GP asking for two things to be done, one of which had been undertaken but not the referral, and the task had been marked as completed.	• Staff were reminded of the need to ensure tasks were read in full, and that if only partially actioned, they needed to be updated and not closed. In addition, all staff had been identified to complete referral training so all team members would be able to action referral requests. We saw that this incident had been discussed at a team meeting.

Effective

This inspection was not rated and therefore the inadequate rating from our inspection in April 2021 remains unchanged.

Effective needs assessment, care and treatment

Care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Explanation of any answers and additional evidence: • Whilst no clinical meetings were in place at our follow up inspection in July 2021, the GPs used an App to share information, for example, links to new and updated guidance. The practice also utilised the task function on their computer to share information or highlight where to find this on the intranet. • The practice told us that formal meetings were not feasible as the locums worked on site on different days. • The lead GP had introduced a programme of locum consultation audits. This would help to evidence that treatment was being delivered in line with standards and evidence-based guidance.	

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) (01/04/2019 to 31/03/2020) (NHS England)	30	47	63.8%	Below 80% uptake
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	42	48	87.5%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	40	48	83.3%	Below 90% minimum

The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	42	48	87.5%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	59	74	79.7%	Below 80% uptake

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 figures quoted in the table above are the same as those used at the April 2021 inspection. These are only updated periodically and due to the short time since our previous inspection, no update was available.
- However, the practice informed us how they working hard to achieve greater uptake. They had introduced a more targeted approach led by one of the locum practice nurses with support from nominated administrative staff. This involved a revised letter and telephone calls to encourage patients to attend with their child for vaccination. They had also implemented a more proactive approach through liaison with the service that sends out the initial appointment letter to be able to monitor and support attendance more easily. The practice produced some unverified data for April and May 2021 which showed uptake was slowly increasing.

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 31/12/2020) (Public Health England)	51.8%	N/A	80% Target	Below 70% uptake

Any additional evidence or comments

- The uptake for this indicator related to cervical screening showed a marginal increase in uptake from 49.9% to 51.8%. However, this figure is only updated quarterly and both this and the previous performance data reported relate to achievement prior to our initial inspection. The practice informed us how they were working to improve targets through letter and telephone conversations to help dispel myths and uncertainties. Planning was underway to introduce an additional monthly session (probably on a Saturday) to provide another option for cervical screening appointments that may benefit those patients who worked full-time.

Effective staffing

The practice was mostly able 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.	partial
The practice had a programme of learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	partial

Explanation of any answers and additional evidence:

- At the inspection in April 2021 we highlighted gaps in staff training and the effective oversight and co-ordination of staff training. At this inspection in April 2021, we found this had improved and we saw evidence that staff had completed most mandatory training.
- The non-clinical practice team were new staff with less than one year's employment within the service. We saw that staff training records relating to the online training system were good, however, there was a need to enhance and embed knowledge and awareness into daily routines, for example, knowledge of how to respond to a complaint.
- Appraisals had not taken place as staff had been in post less than a year, but we were informed that an appraisal process would be implemented in the near future.
- In July 2021, the practice informed us that the lead GP had introduced weekly locum consultation audits to provide assurance on the clinical decision making and prescribing of locum staff. The practice told us that findings were shared and discussed with locums.
- A health care assistant (HCA) working at the practice had increased their hours since our last inspection to incorporate some administrative duties. This gave more flexibility to the service but also meant that the individual had access to the nurses for additional support.

Coordinating care and treatment

Staff were improving how they 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.	partial

Explanation of any answers and additional evidence:

- At the previous inspection in April 2021, the practice could not demonstrate that multi-disciplinary team (MDT) meetings had taken place. We were told that health and social care colleagues were contacted on an individual basis as required to discuss patients. At our inspection in April 2021, we were informed that plans were being developed to formalise their approach. Initially, a meeting was set up with the social prescriber employed through the primary care network, and the practice hoped for this to evolve into a more formalised and regular multi-disciplinary meeting.

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
Explanation of any answers and additional evidence: • We reviewed ten random entries in clinical notes relating to circumcisions as part of our remote patients' records review in July 2021. We saw that all ten patient records had consent details appropriately recorded.	

Well-led

This inspection was not rated and therefore the inadequate rating from our inspection in April 2021 remains unchanged.

Leadership capacity and capability

	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
There was a leadership development programme, including a succession plan.	partial

Explanation of any answers and additional evidence:

- Further to our inspection in April 2021, the practice had developed an action plan with support from their CCG to address the concerns that were highlighted in the four warning notices served against the provider. The action plan was to be enhanced to incorporate all of the areas highlighted for improvement within our last report. We were informed that the practice had been open with staff about the findings and were involving the team in achieving the intended outcomes of the action plan. We saw that staff meeting minutes included reference to the last inspection and the actions being undertaken to improve.
- We saw that the GP had reduced commitments at the local hospital and the circumcision clinic by one session a week respectively. This released more capacity to focus on practice issues. In addition, locum GP session times had been increased, offering more access and choice for patients. One of the locum nurses was due to leave the practice at the end of July 2021, reducing nurse input to one session per week. The practice was considering how they would take this forward, as recruitment had proved to be unsuccessful.
- The practice did not have a formal succession plan in place, although at the time of our inspection in July 2021, a long-term locum GP was in the process of becoming a salaried GP at the practice.
- The practice had moved to a new Primary Care Network (PCN) since the inspection in April 2021. The new arrangement was said to be working well and the practice found that the support from the PCN was valuable and helpful. The GP and practice manager were attending PCN meetings including fortnightly practice manager forums and monthly board meetings.

Governance arrangements

There were clearer responsibilities, roles and systems of accountability to support good governance and management, but more work was needed to achieve full compliance.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	partial
Staff were clear about their roles and responsibilities.	Y

Explanation of any answers and additional evidence:

- Since our previous inspection in April 2021 we found work was being undertaken to improve the oversight of clinical and managerial leadership and governance systems. Systems and processes to assess and continually monitor the service were developing and overseen by senior members of the practice via an inclusive approach with the practice team. Recognising that this will take some time to embed, outcomes will be reviewed at our next inspection.

- Work was ongoing to review practice policies to ensure they were appropriately customised to reflect what happened on site, and were dated and reviewed and updated at specified intervals.

- At our inspection in April 2021, we did not find that the practice had effective oversight of locum clinicians to provide assurances on their work. In July 2021, we observed that the lead GP had implemented an audit of locum GP consultations as part of this. We saw that comments were made and shared with locums where records needed more clarity or advice was offered. There was evidence to support this. We were not informed how the practice received assurances on the work undertaken by locum nurses.

- At the inspection in April 2021 we saw a mobile app was being used within the practice by the GP and locum GPs to discuss patients, and whilst these were anonymised, the level of information was quite detailed. This information was not recorded in the patients' notes. At our inspection in July 2021, we were informed that the app was now used only for general information sharing, for example, new guidance, and any patient specific details were discussed via a more formal route. The practice had established a record of internal discussions held by the GPs to discuss patient care, which was also entered onto the patient record. This had been completed to show that whilst clinical meetings did not take place, clinical issues were being discussed.

- There was no established programme of meetings at our inspection in April 2021. In July 2021, we saw that monthly staff meetings and nurse meetings were in place, and minutes were recorded. Formal child safeguarding meetings were due to commence in August 2021, but multi-disciplinary meetings and clinical meetings still required review.

- Staff appraisals were due to commence in the near future. Employed staff had all been in post for less than a year, but the practice was aware that they needed to introduce a process for this.

- Staff training and induction records had improved since our previous inspection in April 2021.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	partial
There was a quality improvement programme in place.	partial
There were effective arrangements for identifying, managing and mitigating risks.	partial
Explanation of any answers and additional evidence:	

- The practice had focused on addressing the issues raised in our warning notices following the inspection in April 2021. This had helped to improve assurance systems and the arrangements for identifying, managing and mitigating risks. However, some issues were longer-term and required time to become established as well as time to demonstrate their efficacy. Therefore, compliance in this area would be reviewed in more depth at our next inspection.
- We observed that greater oversight to performance in areas such as cancer screening and childhood immunisation uptake was starting to have some impact on outcomes.
- The practice team had greater awareness of responding to risk identified through external audits, for example, fire/health and safety audits and internal mechanisms such as in-house infection control audits and the incident reporting procedure.

Appropriate and accurate information

	Y/N/Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: • Before our inspection in July 2021, the practice submitted an updated Statement of Purpose (SOP) which is a condition of their CQC registration. The practice planned to promote awareness of what issues required a statutory notification reporting to the CQC through staff meetings.	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.

- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease.
- **PHE**: Public Health England.
- **QOF**: Quality and Outcomes Framework.
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ***PCA**: Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see GMS QOF Framework). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- ‰ = per thousand.