

Inspection Evidence Table

Millrise Medical Practice

(1-545508014)

Inspection Date: 07 June 2023

Date of data download: 25/04/2023

Overall rating: Good

Safe

Rating: Requires improvement

At this inspection, we found:

- Not all staff had completed safeguarding training to the required level in accordance with their role.
- There were gaps found in the practice's recruitment processes and recruitment checks were not always carried out in accordance with regulations.
- Evidence that staff vaccination and immunity for potential health care acquired infections was not recorded or risk assessed for all staff.
- A cleaning schedule was not seen for each room and clinical rooms held no signed or dated information on when cleaning had last taken place.
- Fire marshall staff training had yet to take place but was booked for August 2023.
- Blank prescriptions held in printers were not always secure.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	No
There was active and appropriate engagement in local safeguarding processes.	Partial
The Out of Hours service was informed of relevant safeguarding information.	Yes

There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Staff who provided a chaperone service had been in receipt of appropriate training and subject to DBS checks. Additional information was available for staff in respect of Female Genital Mutilation and staff had received Prevent training. (Prevent is about safeguarding individuals from being drawn into terrorism, ensuring those vulnerable to extremist and terrorist narratives are given appropriate advice and support at an early stage).</p> <p>Not all staff had completed safeguarding training to the level required for their role.</p> <p>The practice staff accessed training online from two different providers as well as attendance at some face-to-face events. The practice management team had recognised difficulties in ensuring clear oversight of staff training. Staff training reminders were discussed at the practice's meetings and face to face.</p> <p>Staff were aware of the practice safeguarding lead was and deputising arrangements were in place.</p> <p>The safeguarding lead advised the practice had tried to reconcile/verify the practice safeguard registers to those held by the safeguard local authority teams to ensure accuracy. However, this had yet to come to fruition. This had been escalated in the past in order to find a resolution to the former Clinical Commissioning Group now the Integrated Care Board.</p> <p>The practice invited appropriate health and social care professionals, to discuss vulnerable adults and children at risk of harm.</p> <p>The practice told us they contacted health visitors and school nurses when they needed to discuss a concern and that this was documented in the patients' consultation record.</p>	

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.	No
<p>Explanation of any answers and additional evidence:</p> <p>In three of the six recruitment records reviewed, we found there was a lack of references from prior employers, and one staff member's employment contract no longer reflected the role they undertook and required revision. In two of the six staff records there was not up to date evidence seen of their professional registration.</p> <p>The practice used an occupational health service to ensure staff were fit for their role. However, there had been a change to the occupational health service provider and gaps were found in the provision of occupational health assessments, for example five of the six staff records reviewed held no staff vaccination record. No formal risk assessment was in place for those staff without a full staff vaccination record.</p>	

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Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes
Date of last assessment: June 2022	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 08/02/2023	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: Staff had access to a health and safety handbook. The practice fire risk assessment had identified the need to train and appoint Fire Marshalls, to arrange update training and conduct a fire drill by 31 August 2023. Other risk assessments and checks for example included: <ul style="list-style-type: none"> • The practice 5-year electrical certificate was last updated 1 July 2022. • Portable Appliance Tests (PAT) took place between 29 and 30 January 2022 and the next tests were due in January 2024. • Gas service and servicing took place on 24 June 2022. 	

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.	Yes
Date of last infection prevention and control (IPC) audit: April 2023	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: Staff demonstrated their awareness of the IPC lead nurse who had been newly appointed. The IPC lead had started to appreciate their responsibilities as the lead in this area.	

The practice IPC policy was to be updated in order that all aspects in relation to this policy could be easily located in one document with appropriate links to associated protocols/procedures, for example the practice sharps handling protocol.

- The practice maintained a clinical waste protocol accessible to all staff as well as a Control of Substances Hazardous to Health (COSHH) policy.
- The practice legionella management, testing and investigation policy had been updated and a spreadsheet developed to ensure that regular monitoring checks had been completed.
- The practice had an action plan for areas identified in their IPC audit and the practice management had developed a maintenance log and spreadsheet to ensure areas identified for replacement such as a patient couch could be tracked.
- The practice employed in house cleaning staff. The practice was clean and tidy however, a cleaning schedule was not seen for each room and clinical rooms held no signed or dated information on when cleaning had taken place. There was no evidence seen of the training provided to the cleaning staff in IPC and COSHH.

Cleaners should have a schedule of general cleaning. The schedule should include the cleaning frequency of specific areas, fixtures and fittings. This includes high frequency touch items such as keyboards, telephones, door handles and light switches. It should be checked regularly for compliance and in line with what the general public would expect in health care premises. The policy should include responsibilities for the cleaning of specific clinical equipment.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a generic induction pack which included information on policies, procedures and health and safety at the practice.</p> <p>The practice was in the process of updating its locum/temporary staff file and the draft was scheduled to be discussed at the practice's next clinical governance meeting.</p>	

Staff at all levels recognised the need for additional reception staff and the practice had advertised for these positions. Unfortunately to date there had been a lack of interest in these positions and the practice continued to advertise. During staff absence and at busy times, the practice management team supported the reception staff to take calls and complete tasks where needed. The practice manager advised the practice were mindful of staff wellbeing in particular when agreeing to take up additional hours to cover staff shortages. Staff wellbeing formed part of the practice strategy and had been added to the practice risk register.

The practice had considered its workforce skill mix and planned to increase its practice nurse numbers and, in the future, to add additional GP partners. In the interim period the practice used regular locum GPs to support the GP partners and salaried GPs. The nurse practitioner, clinical pharmacist and nurse associate further supported the practice clinical and nursing team.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results, and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had put measures in place following a significant event in 2022 in relation to individual care record documentation. These measures included but were not limited to:</p> <ul style="list-style-type: none"> • Weekly clinical supervision meetings with each clinician. • The random selection and monitoring review of at least five consultation records per clinician each three months. • Monthly clinical governance meetings. • The implementation of a clinical governance tracker to ensure any resultant actions had a named person responsible and a date for completion. • The practice proposed to add a prescribing review of individual staff alongside the consultation record reviews. <p>A review of patient records in relation to the clinical searches completed on 5 June 2023, identified that care records were managed in a way to protect patients. For example, history, examination, management plans, safety netting and follow up were adequately documented within the patient record.</p>	

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	0.90	0.98	0.86	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). (01/01/2022 to 31/12/2022) (NHSBSA)	7.4%	6.3%	8.1%	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 (01/07/2022 to 31/12/2022) (NHSBSA)	5.08	5.18	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	222.9‰	206.7‰	130.3‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	0.50	0.57	0.56	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	5.6‰	7.3‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Yes

The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>The practice-maintained protocols for staff in respect of the maintenance of vaccine cold chain arrangements and a controlled drugs prescribing. The practice repeat prescribing protocol was at the time of the inspection being reviewed by the clinical pharmacist.</p> <p>Our clinical searches identified systems for monitoring the safe prescribing of medicines requiring regular monitoring. Our clinical searches found for example:</p> <ul style="list-style-type: none"> • 29 out of 40 patients on a particular medicine used in the treatment of rheumatoid arthritis had potentially not been monitored. However, on review it was clear that these patients were all seen in secondary care on a three-monthly basis for their monitoring and there were clear electronic screen alerts in place. • 111 out of 1138 patients on medicines used to lower blood pressure, potentially had not had the required monitoring (Angiotensin-converting enzyme inhibitor (ACEi) or angiotensin II receptor blockers (ARBs). We reviewed 5 of the 111 records and found that 3 patients had been recalled for appropriate monitoring, and 2 had not. On discussion it was found that this was related to changes made by the practice to birthday recall dates. • 17 out of 41 patients on medicines used in the management of neuropathic pain were potentially outstanding a review. An audit was planned on the clinical pharmacist schedule. • 19 out of 262 patients on medicines for hypothyroid, were potentially overdue their thyroid function test monitoring. We reviewed 5 of the 19 patient records and found 2 patients without a recent recall however the practice advised they had recently changed to birthday month recalls, 1 patient was currently out of the UK, 1 patient had recently stopped their medicine and 1 patient had stopped responding to the practice requests to attend for their review. 	

Blank printer prescriptions held in printers were in lockable clinical rooms, but the printers drawers were not lockable, and they were not removed to lockable drawers for security purposes. The practice manager told us systems would be implemented to ensure this took place.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	11
Number of events that required action:	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice maintained a spreadsheet in respect of significant events and incidents, and these were discussed at practice clinical governance meetings as well as being reviewed for trend analysis to avoid the risk of recurrence. The practice had yet to evaluate the actions taken to ensure changes made had become embedded and had mitigated the risk.</p> <p>Staff spoken with confirmed they were comfortable raising concerns and knew the procedure for reporting concerns and safety incidents. Most staff were able to share an example of a recent significant event and the action taken.</p>	

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

Event	Specific action taken
A patients medicines were changed from one type of blood pressure medicine to another. However, instead of the changed medicine being issued, the former and new medicine were issued, and both were taken by the patient.	<p>The medicine error was picked up by the nurse. The nurse ensured that the patients medicine blister pack was amended immediately. The nurse checked the patients' blood pressure and requested the completion of monitoring blood tests within two weeks of the incident.</p> <p>An investigation into the incident took place. It was found that both medicines had been signed off and this was also not picked up by the community pharmacist when placed into medicine blister packs.</p>

	<p>The actions following the incident were: To brief reception team on the process that must be followed when in receipt of a repeat prescription request from a past repeat medicines request.</p> <p>To ensure community pharmacy communications are clear regarding changes to patient medicines.</p>
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a process in place to manage national safety alerts including Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts. No concerns were identified in relation to the Medicines and Healthcare products Regulatory Agency MHRA alert systems.</p> <p>We reviewed a recent patient safety alert for patients prescribed a Sodium-glucose co-transporter-2 (SGLT2) inhibitors, used for treating type 2 diabetes by helping the kidneys to lower blood glucose levels. We sampled 5 out of the 114 records and found they had received the appropriate specific advice and guidance.</p>	

Effective

Rating: Good

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.

At this inspection, we found:

- Some gaps were found in the completion of staff training, such as safeguarding training and mental capacity act training. Learning disability training for the staff member with responsibility for their annual reviews had taken place and training concerns identified have been reflected in the safe domain.
- Improvements were needed in the uptake of cervical screening.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Yes
The practice prioritised care for their most clinically vulnerable patients.	Yes
Explanation of any answers and additional evidence:	
The practice had put measures in place following a significant event in 2022 in relation to individual care record documentation.	
Clinicians we spoke with, told us they were kept up to date with current evidence-based practice during clinical governance meetings and training events held. They had access to updates on their electronic systems such	

as templates. Regular monthly clinical governance meetings were held to facilitate discussion about work priorities, complex cases and share any new and revised best practice guidance. Clinical staff attended weekly clinical supervision.

The practice held registers, including those for patients with a learning disability, mental health condition, palliative care and long-term conditions. The practice had a nominated staff member for patients with a learning disability who completed these reviews, and this had assisted in the development of positive patient and staff rapport. We noted the staff member had completed relevant training

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty.
- Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice held monthly palliative care meetings. The practice cancer care coordinator contacted patients every 3 months to ensure patients' needs were updated and any referrals made in a timely manner to any additional services required and six monthly for those whose condition was considered stable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- The practice provided a service to patients who are veterans, any newly registered veteran had an initial 20-minute appointment and identification of veteran status was included on the practice registration form.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Our clinical searches found, 60 out of 599 patients with diabetic retinopathy (a complication of diabetes) had a specific blood test result that was greater than 74mmol/l. We sampled 5 of the 60 records and all had been in receipt of a review.
- Our clinical searches found, 46 out of 596 patients with asthma were on short-acting beta-agonists (SABAs) rescue medicines used to treat asthma symptoms quickly. We sampled 5 records, and all had been prescribed an inhaled corticosteroid and had an asthma review completed. GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Our clinical searches found 74 out of 596 patients with asthma had been prescribed two or more courses of rescue steroids. We reviewed 5 of the 74 and found no concerns.
- Our clinical searches looked at possible missed diagnosis, in particular in relation to diabetes monitoring and coding, and chronic kidney disease level 4/5, we found no concerns. The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	57	59	96.6%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e., received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	84	86	97.7%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e.,	84	86	97.7%	Met 95% WHO based target

received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)				
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	84	86	97.7%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	66	71	93.0%	Met 90% minimum

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

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 60-74, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	66.6%	63.9%	66.8%	N/A
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	78.4%	69.7%	61.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	49.2%	53.2%	54.9%	No statistical variation
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). (30/09/2022 to 30/09/2022) (UKHSA)	77.3%	N/A	80.0%	Below 80% target

Any additional evidence or comments
<p>The practice was aware of the cervical screening targets and that the 2022 target had not been met.</p> <p>The practice nursing team had been supported by a locum practice nurse once the long-term practice nurse had retired, in order to assist and the practice hoped to recruit another practice nurse.</p> <p>Information in respect of cervical screening was held on posters within the practice reception areas and on the practice website.</p>

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>The practice completed an audit between April and November 2022 on antibiotic prescribing in acute sore throat patients. The total number of patients in the audit was 15. The findings were:</p> <ul style="list-style-type: none">• 13% of patients had had a pain score completed.• 27% had no antibiotic prescribed.• 73% had an immediate antibiotic prescribed.• 0% had a back-up/delayed antibiotic given with advice.• 7% had advice given on natural history and average length of illness 7 days.• 33% had advice about managing symptoms.• 100% had information provided about when to re-consult.• 0% had information given about antibiotic use and resistance.• 0% had a Treating Your Infection leaflet shared with patient.• 100% had an antibiotic choice which was correct.• 100% had the correct dose/frequency of the antibiotic.• 91% had the antibiotic course length correct. <p>Recommendations were made to improve compliance.</p> <p>The practice completed a second audit in December 2022 and found there had been only marginal impacts made following their recommendation. However, during the time of the second audit, a scarlet fever alert was in place which included potential bacterial throat infections to which antibiotic prescribing tolerance was affected.</p> <p>Some findings were lower than the previous audit for example:</p> <ul style="list-style-type: none">• The prescribing of the correct antibiotic, for the correct duration and dose was 82%, which was lower than the previous audit results of, 100%.• 33% of patients had been given safety netting advice which was lower than the 100% achieved in the previous audit.• However more viral illnesses were picked up in the second audit as the audit found 33% of patients had no antibiotic prescribed which was higher than the previous audit result of 27%. <p>Further recommendations were made including a reaudit scheduled for June 2023. These included:</p> <ul style="list-style-type: none">• All clinicians to revisit and reflect on their use of pain scores to support their clinical diagnosis.	

- The addition of pneumonic (SADOS) to each workstation to support a holistic consultation. (SADOS pneumonic; Score (Pain), Antibiotics, Duration of illness, Over the counter products available and leaflet, Safety netting).
- Compliance with The National Institute for Health and Care Excellence and UK Health Security Agency (UKHSA) in antibiotic prescribing; ensure the correct antibiotic, dose/frequency and course length prescribed. Use the local medicines formulary as a support tool to ensure the most up-to-date local prescribing.
- Encourage the use of Royal College of General Practitioners (RCGP) TARGET leaflets, which were produced in 25 languages. These leaflets were designed to be printed, shared with patients and completed with them during consultations. It explained their diagnosis, the decision about antibiotics, when and how to use a backup/delayed antibiotic option, the natural period of their illness, self-help management, safety netting and the need for safe antibiotic prescribing to minimise antibiotic resistance.
- Re-audit in 6 months: Due 28/06/22

Any additional evidence or comments

The practice had implemented an audit planner which outlined the type of audit, the date of the first audit, the date of the second planned audit and audits for future consideration.

Effective staffing

The practice was unable to demonstrate that staff had all 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.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Not all staff had completed the training in line with their role. The practice manager told us staff had been in receipt of training reminders and had protected time for learning and development. Some staff had attended external training events and others completed online training via two different training software systems. The practice manager advised they hoped to introduce changes to ensure that there was clear oversight of all staff training regarding the format to ensure staff had the appropriate skills and knowledge for their role. Learning disability training for the staff member with responsibility for their annual reviews had taken place and training concerns identified have been reflected in the safe domain.</p>	

Clinicians had weekly clinical supervision sessions and competency reviews which included a review of consultation records each 3-month period which were documented.

Practice staff had not had an annual appraisal. The practice was aware, and plans were in place for these when the new practice manager took up their position in July 2023.

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

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

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. 1	Yes
<p>Explanation of any answers and additional evidence,</p> <p>The practice had developed a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) policy which was accessible to all staff on the practice electronic shared drive.</p> <p>Our clinical review of notes where a DNACPR decision had been recorded identified where possible the patients views had been sought and respected.</p>	

Caring

Rating: Good

Kindness, respect and compassion

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

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

Patient feedback	
Source	Feedback
Practice patient compliments and comments	Patients through the practice compliments, friends and family tests and their software messaging systems enable patients to feedback on their treatment and care and some staff had been singled out for praise.

National GP Patient Survey results

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	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	89.9%	83.8%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare	89.1%	82.0%	83.5%	No statistical variation

professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)				
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	98.5%	91.8%	93.1%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	86.6%	72.4%	72.4%	No statistical variation

Any additional evidence or comments

The practice had scored higher than their ICS average in every question.

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

Any additional evidence

The practice reviewed patient experience via their software text messaging service as well as the Friends and Family Test results the National GP Survey results and complaints and compliments received.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence: Easy read and pictorial materials were available.	

National GP Patient Survey results

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	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they	94.7%	88.8%	89.9%	No statistical variation

wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)				
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	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	261 patients were recorded as being a carer on the practice carer register representing 3.2% of the practice list (approximately; 8.12K).
How the practice supported recently bereaved patients.	The practice manager told us they sent condolence cards and an offer of a face-to-face appointment with the GP for those patients who were bereaved.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence: Staff received training from induction to ensure patients respected patients' privacy and dignity.	

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We discussed the practice website information which noted what new patients needed to do in order to register with the practice which included a form of identity check. The practice manager advised they would consider changes to practice website to ensure it was clear when registering at the practice should the patient be for example homeless that a form of ID would not be required.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am - 6pm
Tuesday	8am – 12pm and 2pm to 6pm Staff training 12pm to 2pm
Wednesday	8am - 6pm
Thursday	8am - 6pm
Friday	8am - 6pm
Appointments available:	
Monday	8.30am – 12pm 2pm to 5.20pm

Tuesday	8.30am – 12pm 2pm to 5.20pm
Wednesday	8.30am – 12pm 2pm to 5.20pm
Thursday	8.30am – 1pm Between 1pm to 6pm the out of hours service takes the practice calls. The practice is open however between 2pm and 5.20pm with their pre booked appointments
Friday	8.30am – 12pm 2pm to 5.20pm
Enhanced access: These appointments were pre bookable via the practice but would not necessarily be at the practice. The health professionals providing the enhanced service had access to patients full medical record, with patient consent.	

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> Patients had a named GP who supported them in whatever setting they lived. The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues. All parents or guardians calling with concerns about a child, were offered a same day appointment when necessary. Pre-bookable appointments were available to all patients at additional locations within the area, under the enhanced access scheme. Enhanced access included some appointments on Saturday and Sunday. The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability. People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers. The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Yes
The practice offered a range of appointment types to suit different needs (e.g., face to face, telephone, online).	Yes
Patients were able to make appointments in a way which met their needs.	Yes
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised.	Yes

There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes
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National GP Patient Survey results

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	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	54.8%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	58.6%	58.4%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	56.1%	58.3%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	70.5%	73.3%	71.9%	No statistical variation

Source	Feedback
NHS.uk website (formerly NHS Choices)	Held no reviews of the practice
Practice Facebook	18 reviews and rated 4.6 out of five stars

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	6
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	6
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient raised a complaint in respect of gaining access to appointments via the phone	<p>The complaint was acknowledged, investigated and the complaint findings fed back to the complainant. Apologies were appropriately offered, and the practice described their plans for a new telephony service in the near future.</p> <p>The patient was satisfied with the practice response but had also been offered information on the next steps they could take should they not be satisfied with the practice response.</p>

Well-led

Rating: Good

At this inspection we found:

- The need for the newly developed practice strategy and formalised succession plan to be ratified, implemented and embedded.
- The lack of a systematic approach to maintain clear oversight on all staff training and appraisals.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Succession planning had been informally described and discussed but had yet to be formally documented as part of the practices overall strategy.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Partial
Explanation of any answers and additional evidence: <p>The practice staff were aware of the practice's mission statement which was to provide a high standard of patient-focused healthcare in a responsive, supportive and courteous manner whilst ensuring that all patients and staff are treated with dignity, honesty and respect.</p> <p>The practice had developed a set of strategic aims and values. The aim being to increase the benefits to the community they serve with more patients receiving good patient care and to play their role in reducing health inequalities.</p>	

The practice aimed to:

- Enhance their positive culture and provide greater training opportunities for staff.
- Further enhance strong partnerships with other organisations
- Improve service quality through innovation and by adopting practical ways of involving patients in the delivery of their services.
- Contribute to addressing health inequalities by tailoring their services to the communities they serve, working with the Primary Care Network.
- Work with staff to improve health and wellbeing.
- Ensure their service is financially and environmentally sustainable, achieving standards that improve service quality.
- Improve access using new technology.

The practice three-year plan although not detailed outlined their ambition which had yet to be monitored but included:

- Successful recruitment following a change in practice management with long term practice manager retiring.
- Patient services and service development, for example a proposal to change the telephony system to a cloud-based system.
- Communication
- Workforce planning and skill mix, for example to recruit a practice nurse, to support their new salaried GPs ambition to become a GP trainer.
- Patient Participation Group (PPG) recruitment
- To become a dementia friendly practice.
- To become Learning Disability Champions.
- Staff wellbeing
- Regular monthly meetings which include the Integrated Care Board (ICB) and GP Federation members. The meetings include the introduction of new pathways in which practices present can add in suggestions and ideas for improvement. Development of close working relationships and the development of plans on how to work at scale across the city.

The practice's draft strategy and practice risk assessment was planned to be discussed with the whole team to ensure a collaborative approach, adding their ideas and suggestions.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>We received positive feedback from staff in respect of the practice culture. Staff described an 'open' and 'transparent' approach by all leaders. Staff said they felt able to raise concerns, were listened to and that any appropriate actions would be taken. Staff shared personal examples of how their well-being had been respected by the management team.</p> <p>Three staff had not undertaken equality and diversity training.</p>	

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

Source	Feedback
Staff feedback questionnaires and staff spoken with	<ul style="list-style-type: none"> • All staff reported positively on leaders being visible and approachable. • All staff reported positively on the practice culture, all reported they could speak up and would be supported to do so without fear of retribution. • Staff enjoyed their work despite at times being short of staff as they recognised that the practice had and continued to advertise to recruit to vacant positions. • Staff felt their wellbeing was considered. • Staff reported that the Lead GP was very approachable, listened to their views and that all GPs supported them when needed. • All felt valued as members of the practice team. • Staff reported that during the period of transition between practice managers, it would be useful to have a documented organisational chart in order to know which manager they should go to for support. This was put in place during the inspection and shared with staff. • Staff reported they would value having more regular whole staff meetings.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice ensured staff were aware of their responsibilities for Information Governance (IG) standards and provided a code of conduct and policy which set out clear guidance.</p> <p>Staff were in receipt of job descriptions, had induction training and were subject to competency reviews to enable them to be clear about their roles and responsibilities. The practice held multi-disciplinary meetings with other allied health professionals for those patients assessed as end of life and with frailties and attended Primary Care Network meetings.</p> <p>We looked at whether there were any workflow letters or pathology back logs and found that activity was monitored, including whether there were back logs to allay delays to treatment.</p> <p>The provider maintained a clinical governance protocol which included:</p> <ul style="list-style-type: none"> • Clinical effectiveness and research • Audit • Risk management • Education and training • Patient and public involvement • Using information and IT • Staffing and staff management <p>These were reviewed at regular monthly meetings chaired by the Clinical Governance Lead or the senior partner. All clinicians in a consulting role (including PCN staff) were invited to attend the meeting. Minutes were taken for each meeting and disseminated to all clinicians (present and not present) by email.</p> <p>The practice audited clinical notes on a rolling programme, with randomly selected consultations reviewed with a minimum of 5 consultations per clinician. Initially the audits were to be completed quarterly and eventually annually. Two of the GP partners completed audits of consultations undertaken by Primary Care Network staff. Audits were also completed on prescribing which included:</p> <ul style="list-style-type: none"> • Ensuring the medicine was appropriate to diagnosis. • Ensuring the medicine was prescribed according to guidelines. • Ensuring the records and medicine record keeping quality was appropriate. <p>The practice maintained a clinical governance action tracker which provided a risk stratification of the action to be taken, who was responsible for the action and a deadline date for completion.</p> <p>A range of internal and external meetings were held by the practice, these included for example:</p> <ul style="list-style-type: none"> • Practice meetings • Palliative care meetings • Primary Care Network (PCN) meetings • Clinical governance meetings which included GPs, nurses and the pharmacy team. 	

- Whole team meetings
- Practice partner meetings
- Weekly administration and reception meetings

Managing risks, issues and performance

There were some 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 were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>There were a few gaps seen in the practice's quality assurance systems for example:</p> <ul style="list-style-type: none"> • Staff training oversight • Recruitment • Appraisals • Cleaning staff training and cleaning schedules • Improved verbal complaint systems • PPG recruitment • Regular whole team meetings <p>It was clear from discussion with the practice management and clinical team that the practice had awareness of gaps in their assurance systems and had commenced work to make appropriate improvements. For example, they had recently developed a practice risk register with staff responsible for mitigating actions which would be signed off once complete.</p> <p>The practice recognised the need to discuss and describe its strategy/business planning and development processes. This was to ensure these were clearly identifiable as the aspirations for the practice, as well as having clear processes for considering the impact on quality and sustainability within the practice when considering future practice or service developments.</p>	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes

Governance and oversight of remote services

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group (PPG).	No
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes

<p>Explanation of any answers and additional evidence:</p> <p>Staff we spoke with knew how patient views about the service were gained for example, through Friends and Family Test, compliments, complaints and patient surveys.</p> <p>The practice PPG following the pandemic had not been active. The practice had been proactive in its attempt to recruit to the PPG and to ensure where able that the PPG membership reflected and represented its registered patient population. The recruitment to the PPG was ongoing at the time of the inspection.</p> <p>The practice worked closely with their Primary Care Network (PCN). Patients had access to pharmacists, pharmacy technicians, a social prescriber, dietitian, a mental health practitioner and first contact physiotherapists who worked with the practice helping to alleviate some of the pressures on the GPs. Monthly PCN meetings were held, and audits were shared, and quality improvement activities discussed.</p>
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Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had reviewed, expanded and upskilled the practice workforce to meet their increasing patient population and demands and the difficulties in recruiting to some positions within the practice.</p> <p>The practice had an audit program. We saw that action plans following audits were developed and monitored and that learning from audits was shared with relevant staff.</p>	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

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