

# Care Quality Commission

## Inspection Evidence Table

### Beacon Medical Practice (1-591810663)

Inspection date: 6 and 10 August 2021

Date of data download: 26 July 2021

## Overall rating: Good

At our previous inspection on 20 October 2020 we rated the practice as good for providing safe and effective services, requires improvement for providing caring and well-led services and inadequate for providing responsive services. At this inspection we found the issues leading to the requires improvement and inadequate ratings had been addressed.

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

## Safe

## Rating: Good

### Safety systems and processes

The practice had 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.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes (1)
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Partial (2)
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
Explanation of any answers and additional evidence:	

Safeguarding	Y/N/Partial
(1) 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.	
(2) Children about who there were safeguarding concerns had a marker on their clinical record front screen to alert staff. No such alerts were applied to adults about who there were concerns. Likewise, the parents and adult family members of children about who there were concerns were not highlighted to staff.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: September 2020	Yes
There was a record of equipment calibration. Date of last calibration: January 2021	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
A fire risk assessment had been completed. Date of completion: March 2021	Yes
Actions from fire risk assessment were identified and completed.	Yes

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

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

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

## 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

## 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 (1)

There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence: (1) Each day, new pathology results were allocated to the GPs at work on that day. The GP reviewed the results on the day and took any action as well as informing the GP who requested the test of the results via a task on the clinical system. Test results in the pathology inbox were reviewed. On the day of inspection, 6 August, all blood results waiting to be reviewed were from 5 and 6 August.	

## Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	1.05	0.88	0.70	Variation (negative)
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). (01/04/2020 to 31/03/2021) (NHSBSA)	9.8%	12.6%	10.2%	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 (01/10/2020 to 31/03/2021) (NHSBSA)	6.18	5.57	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	474.4‰	217.2‰	126.9‰	Significant Variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	0.75	0.93	0.66	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) <small>(NHSBSA)</small>	9.5‰	8.2‰	6.7‰	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 (1)
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 structured 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 (2)
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 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 (3)
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 (4)
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 PHE guidance to ensure they remained safe and effective.	Yes (5)
Explanation of any answers and additional evidence:	

1. There were systems in place to keep blank prescription stationery secure and monitor usage throughout the practice however the system was not always being followed appropriately. We found that the branch sites were not logging prescriptions at the end of the day and found evidence of some prescriptions being left in printers overnight which was against the practice policy, although the doors to the rooms were locked when not in use. Following the inspection, the practice provided us with an action plan and written assurances to ensure the safe storage and tracking of stationary.
2. Pregabalin and Gabapentin prescribing was higher than local and national averages. The practice had an elderly population with chronic pain issues who cannot take other forms of analgesia because of other health problems. Some prescriptions have been initiated in secondary care by the Pain Clinic or Mental Health Team. The practice was ensuring patients on these medications had regular medication reviews and were followed up after two to three weeks when started on Pregabalin or Gabapentin. Five records of patients prescribed both Gabapentin and Pregabalin in the last 12 months were reviewed. None of these patients were on both medications simultaneously and they were all taking the medication for chronic or nerve-related pain. There was evidence that these patients were being regularly followed up and reviewed.
3. Antibiotic prescribing was higher due to the practice having an elderly population with high levels of chronic disease (e.g. asthma and COPD). The practice had 31 cases of sepsis last year. 30 of these were in the over 60 age group. More rescue packs for asthma and COPD have been issued as a result of the COVID-19 pandemic. The practice is planning to audit the issue of rescue packs to help reduce antibiotic prescribing. The practice has had discussions with secondary care regarding safe prescribing of antibiotics in telephone consultations and has audited antibiotic prescribing for urinary tract infections.
4. We found that one emergency medicine was not available at one branch surgery due to it being out of stock and unavailable. It had been recorded that it was out of stock and had been ordered. The medicine was available at another branch site if required, but in any event an alternative medicine was held. Following the inspection, the practice informed us that the medicine had been sourced from an alternative supplier.
5. There were systems in place to ensure that vaccines and medicines requiring refrigeration were stored appropriately with fridge monitoring occurring. We found evidence one fridge had been reported over the recommended maximum temperature of 8 degrees and no actions had been taken. This was identified as an error with the reporting form not being clear that where temperatures exceeded 8 degrees action needed to be taken and we were assured the form would be updated immediately. There was nothing to suggest that the efficacy of the medicines had been compromised as a result. They acknowledged the form could be adapted to ensure staff were prompted to act when the temperature exceeded 8 degrees.

<b>Dispensary services (where the practice provided a dispensary service)</b>	<b>Y/N/Partial</b>
There was a GP responsible for providing effective leadership for the dispensary.	Yes
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Yes
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Yes
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Yes
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Yes
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Yes
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Yes
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Yes (1)
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes
<p>Explanation of any answers and other comments on dispensary services:</p> <ol style="list-style-type: none"> <li>1. We saw evidence of near misses being reported and learning events being reported and acted on. We also saw evidence of dispensing errors being reported as significant events with appropriate investigations.</li> </ol>	

## **Track record on safety and lessons learned and improvements made**

### **The practice learned and made improvements when things went wrong.**

<b>Significant events</b>	<b>Y/N/Partial</b>
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:	33
Number of events that required action:	all
Explanation of any answers and additional evidence:	
<p>The practice termed significant events as 'Learning Events' and thus all required action. Although the events were well documented, it was not apparent how the learning had been cascaded to staff as it was not recorded how this had been achieved. We did however see that they had been discussed at clinical meetings and those that were not clinically related at Team Leader meetings but they were not linked and so it was not possible to show an audit trail from reporting through to learning. Following the inspection, the practice provided us with written assurances of how they intended to address the issue. The practice was producing a newsletter that would contain relevant learning from such events.</p>	

Example of significant events recorded and actions by the practice.

Event	Specific action taken
A learning event was discussed where a patient had come to reception to collect some medication but had been sent to somewhere else when the medication was at the reception desk. The patient had complained.	The learning from this incident was that staff should always ask advice if they are not sure and that staff should include more specific instructions in the patient's records.

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
Explanation of any answers and additional evidence:	
<p>We reviewed three Medicines and Healthcare products Regulatory Agency (MHRA) alerts and found that appropriate action had been taken in each case.</p> <ul style="list-style-type: none"> <li>• Valproate: All records complied with the MHRA pregnancy prevention guidance.</li> <li>• Clopidogrel/Omeprazole: five records were reviewed, and patients had been switched from Omeprazole to an alternative.</li> <li>• Simvastatin/Amlodipine: three records were reviewed, and action had been taken either to stop Amlodipine or to switch to an alternative statin.</li> </ul>	



## Effective

## Rating: Good

### Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment 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
Explanation of any answers and additional evidence:	

## Older people

## Population group rating: Good

### 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. Of the 629 of patients with severe frailty, 623 were reviewed in the last 12 months.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. The practice aimed to review these patients within three days of discharge. In July 2021 all 142 patients were reviewed within that timeframe and there had been a steady and sustained increase from a low of 52% in September 2020.
- The practice carried out structured annual medicines reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age. 2,871 or 92% of patients falling in this group were seen in the last 12 months.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## People with long-term conditions

Population group rating: Good

### Findings

- Despite the Covid-19 pandemic the practice had continued to deliver annual reviews by telephone and face to face where appropriate.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	67.6%	78.8%	76.6%	Tending towards variation (negative)
PCA* rate (number of PCAs).	19.2% (333)	10.0%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	64.6%	87.9%	89.4%	Significant Variation (negative)
PCA rate (number of PCAs).	5.6% (61)	10.0%	12.7%	N/A

\*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	77.1%	82.6%	82.0%	No statistical variation
PCA* rate (number of PCAs).	4.2% (41)	4.8%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	54.8%	68.8%	66.9%	Tending towards variation (negative)
PCA rate (number of PCAs).	7.1% (139)	13.8%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	68.4%	73.5%	72.4%	No statistical variation
PCA rate (number of PCAs).	5.7% (224)	6.7%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) <small>(QOF)</small>	90.5%	94.0%	91.8%	No statistical variation
PCA rate (number of PCAs).	1.3% (10)	3.2%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	72.5%	78.5%	75.9%	No statistical variation
PCA rate (number of PCAs).	6.3% (122)	9.2%	10.4%	N/A

\*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

### Any additional evidence or comments

The records review showed that some asthma reviews were overdue. The negative variation in some QOF measures (i.e. Asthma, COPD and Diabetes) were discussed with a GP. A new Nursing Lead with a special interest in diabetes had been recruited and was looking at coding and diabetes reviews. Asthma and COPD reviews have been difficult during the COVID-19 pandemic as the practice was not able to do spirometry.

## Families, children and young people

## Population group rating: Requires improvement

### Findings

- The practice had not met the minimum 90% for any of the five childhood immunisation uptake indicators. Evidence we reviewed showed that the practice was making every effort to contact and encourage parents to have their children immunised.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

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)	146	173	84.4%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	179	200	89.5%	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)	176	200	88.0%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	176	200	88.0%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles,	159	191	83.2%	Below 90% minimum

mumps and rubella (two doses of MMR)  
(01/04/2019 to 31/03/2020) (NHS England)

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

### Any additional evidence or comments

The practice had continued to offer childhood immunisations during the COVID-19 pandemic. Children who are not brought for their immunisations are followed up, and we saw evidence to support this. The Health Visitor also contacted families to encourage them to attend for immunisations.

### Working age people (including those recently retired and students)

Population group rating: Good

### Findings

- 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.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.
- Cervical screening uptake was low. The COVID-19 pandemic has had an impact on people wanting to attend for screening despite the practice being willing and able to provide the service throughout. The practice was planning to offer catch up sessions for cervical screening in the evenings after school/work now COVID-19 restrictions are easing. The practice offers extended hours up to 8pm to allow working adults or mothers to have a smear after work.

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)	71.9%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	63.6%	74.2%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	57.4%	65.9%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	100.0%	92.7%	92.7%	N/A

Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) <sup>(PHE)</sup>	55.2%	54.6%	54.2%	No statistical variation
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**People whose circumstances make them vulnerable**

**Population group rating: Good**

Findings
<ul style="list-style-type: none"> <li>• Same day appointments and longer appointments were offered when required.</li> <li>• All patients with a learning disability were offered an annual health check.</li> <li>• End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.</li> <li>• The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.</li> </ul>

**People experiencing poor mental health (including people with dementia)**

**Population group rating: Good**

Findings
<ul style="list-style-type: none"> <li>• The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.</li> <li>• Same day and longer appointments were offered when required.</li> <li>• There was a system for following up patients who failed to attend for administration of long-term medicines.</li> <li>• When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.</li> <li>• Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.</li> <li>• Patients with poor mental health, including dementia, were referred to appropriate services.</li> </ul>

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	94.8%	84.9%	85.4%	No statistical variation
PCA* rate (number of PCAs).	43.9% (76)	25.3%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	98.1%	84.5%	81.4%	Significant Variation (positive)
PCA rate (number of PCAs).	18.7% (49)	9.7%	8.0%	N/A

\*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

#### Any additional evidence or comments

We found that the higher than average PCA rates were appropriate.

#### 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/There was limited monitoring of the outcomes of care and treatment.

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	514	533.9
Overall QOF score (as a percentage of maximum)	91.9%	95.5%
Overall QOF PCA reporting (all domains)	6%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

The practice provided evidence of eighteen clinical audits that had been completed.



These included several repeat cycle audits including a two-cycle audit of non-medical prescribers which showed improvement and an audit of antibiotic prescribing for urinary tract infections which had resulted in better prescribing practice.

## Effective staffing

**The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.**

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Partial (1)
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: (1) Respondents to staff questionnaires showed a mixed picture. Generally clinical staff said they had protected time whilst many non-clinical staff stated they used their protected learning time to catch up on work back-logs.	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
Explanation of any answers and additional evidence: The care coordinator reviewed all hospital discharges of older people. In July 2021 all 142 patients were reviewed within three days of discharge.	

## Helping patients to live healthier lives

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

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

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to decide.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes

## Caring

**Rating: Good**

At our previous inspection we rated the practice as requires improvement for providing caring services. This was a result of the dissatisfaction expressed by patients.

At this inspection we found the issues had been addressed.

### Kindness, respect and compassion

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

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

### National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	84.1% (75%)	88.9%	89.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	80.6% (72.6%)	87.7%	88.4%	Tending towards variation (negative)
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 (01/01/2021 to 31/03/2021)	92.8% (86%)	95.9%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	58.6% (47.6%)	82.0%	83.0%	Variation (negative)

### Any additional evidence or comments

The practice had shown significant improvement all four of the indicators compared to the previous GP Patient Survey for the period 01/01/2020 to 3/03/2020 the results of which are shown in brackets, although all were still below CCG and national averages.

The practice had received 72 written compliments from patients and carers in the last 12 months of which 50 had been received in April, May and June 2021. The compliments covered all staff groups.

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

### Any additional evidence

The practice carried out its own patient survey, contacting patients following their consultation. This was up to date data and demonstrated high levels of satisfaction. For example, of 375 responses between 5 April and 24 June 2021, 98% found the person they spoke to helpful and 91% said they would recommend the practice to family and friends.

### Involvement in decisions about care and treatment

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

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

### National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	85.9%	92.8%	92.9%	Tending towards variation (negative)

### Any additional evidence

This figure had slightly reduced from 87.7% in the GP Patient Survey for 01/01/20 to 31/03/2020



	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.	304, which was 1.5% of the list size.
How the practice supported carers (including young carers).	Carers information was available both in the practice and on their website.
How the practice supported recently bereaved patients.	The practice provided a comprehensive guide for the bereaved including practical advice on registering a death, funerals and emotional and financial support. Further signposting to bereavement support was available on the practice website.

## Privacy and dignity

### The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes

## Responsive

## Rating: Good

At our previous inspection in October 2020 we rated the practice as inadequate for providing responsive services. This was the result of patient dissatisfaction with telephone access to the practice and the practice not having taken steps to address it.

At this inspection we found that the practice had made significant improvements.

### 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

Day	Time
Opening times:	Skegness
Monday	8am to 8pm
Tuesday	8am to 8pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
	Chapel St Leonards
Monday	8am to 4.30pm
Tuesday	8am to 4.30pm
Wednesday	8am to 4.30pm
Thursday	8am to 4.30pm
Friday	8am to 4.30pm
	Ingoldmells
Monday	8am to 4.30pm
Tuesday	8am to 4.30pm
Wednesday	8am to 4.30pm
Thursday	8am to 4.30pm
Friday	8am to 4.30pm



GP extended hours appointments were available from 6.30pm to 8pm Monday to Friday and 8.30am to 7pm on Saturday, Sunday and bank holidays at the Ingoldmells branch surgery and delivered by a different healthcare provider.

## Older people

## Population group rating: Good

### Findings

- All 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 provided effective care coordination to enable older patients to access appropriate services.
- There was a medicines delivery service for housebound patients.

## People with long-term conditions

## Population group rating: Good

### Findings

- The practice was actively working towards ensuring patients with co-morbidities were able to have their healthcare needs met by a single visit to the practice, rather than separate appointments for different conditions.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

## Families, children and young people

## Population group rating: Good

### Findings

- The practice was open until 8pm on a Monday and Tuesday at the Skegness surgery. Pre-bookable appointments were also available to all patients at the extended hours hub held at Ingoldmells branch surgery by a different provider. Appointments were available from Monday to Friday from 6.30pm to 8pm and on Saturday, Sunday and bank holidays from 8.30am to 7pm.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

## Working age people (including those recently retired and students)

Population group rating: Good

### Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 8pm on a Monday and Tuesday at the Skegness surgery. Pre-bookable appointments were also available to all patients at the extended hours hub held at Ingoldmells branch surgery by a different provider. Appointments were available from Monday to Friday from 6.30pm to 8pm and on Saturday, Sunday and bank holidays from 8.30am to 7pm.

## People whose circumstances make them vulnerable

Population group rating: Good

### Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travelers and those with a learning disability.
- The practice was open until 8pm on a Monday and Tuesday at the Skegness surgery. Pre-bookable appointments were also available to all patients at the extended hours hub held at Ingoldmells branch surgery by a different provider. Appointments were available from Monday to Friday from 6.30pm to 8pm and on Saturday, Sunday and bank holidays from 8.30am to 7pm.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

## People experiencing poor mental health (including people with dementia)

Population group rating: Good

### Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- The practice was open until 8pm on a Monday and Tuesday at the Skegness surgery. Pre-bookable appointments were also available to all patients at the extended hours hub held at Ingoldmells branch surgery by a different provider. Appointments were available from Monday to Friday from 6.30pm to 8pm and on Saturday, Sunday and bank holidays from 8.30am to 7pm.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

## Access to the service

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

	Y/N/Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes
Patients were able to make appointments in a way which met their needs.	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes
There were systems in place to support patients who face communication barriers to access treatment.	Yes
Patients with urgent needs had their care prioritised.	Yes
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Yes

## National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	30.0% (20.1%)	66%	67.6%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	47.6% (21%)	70.9%	70.6%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	49.6% (33.9%)	67.2%	67.0%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	72.7% (44.9%)	84.7%	81.7%	No statistical variation

## Any additional evidence or comments

The practice had demonstrated significant improvement in all these GP Patient Survey indicators when compared to the previous survey from 01/01/2020 to 31/03/2020 which are shown in brackets in the table, albeit they were still below the CCG and National Average. The data for the survey had been collected

prior to the improvements to the practice telephony system had been implemented. Partners and managers told us that they considered continuing improvement in this area a priority.

Improvements in the telephony system could be demonstrated. For example, the number of abandoned calls in January 2021 had been 8563 or 48% of the total received. In July 2021 this had reduced to 979 or 7% of calls received. The longest wait time for calls after 9am in January 2021 had been 57mins and 38 seconds. This had steadily reduced to the longest wait time being 11 minutes and 56 seconds in July. The average wait times for calls both before and after 9am had better than halved in the same period, being 2 minutes 26 seconds before 9am and 3 minutes 4 seconds after 9am in July 2021.

Source		Feedback
Practice survey	patient	<p>The practice had carried out its own survey of patients using the service, immediately following their consultation/appointment. This ensured feedback related to the changes made to the telephone/appointment system and the current service delivery, assuring the provider that changes made had improved satisfaction. This survey took place between 5 April and 24 June 2021.</p> <p>Of 375 respondents, 357 (95%) felt their call was answered quickly. 282 (75%) said their appointment was a time convenient to them.</p>
CCG Clinic	Listening	<p>The Clinical Commissioning Group carried out a listening clinic across all three surgeries on 29 June 2021. A total of 91 people were asked for their experiences across several areas. Generally, respondents stated that their experience of getting through on the telephone had much improved. The CCG confirmed that the results were more positive than the previous listening clinic.</p> <p>Of the 41 people at the Skegness surgery who responded to the question regarding telephone access 22 stated it had improved, nine had positive and negative comments and ten negative comments. At Chapel St Leonards nine of 13 stated it had improved recently and two had both positive and negative views. At the Ingoldmells surgery eight of 11 respondents said telephone access had improved.</p>

## 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.	68
Number of complaints we examined.	10
Number of complaints we examined that were satisfactorily handled in a timely way.	10
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Nil

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

Explanation of any answers and additional evidence:

The practice had reviewed their complaints policy and process to make it clearer and remove any ambiguities. In order to reinforce the process, they recently appointed a dedicated complaints coordinator who reported directly to the Practice Manager and GP Partner complaints lead.

Whilst the recorded complaints were clear and concise in their explanations, there was no evidence that any learning had been cascaded to staff or that any action had been taken as result of that learning to prevent re-occurrence. Following our inspection, the practice provided us with an action plan and assurances that this would be addressed.

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient given wrong information regarding flu vaccinations.	Patient contacted and appointment made. Staff reminded of guidelines

## Well-led

Rating: add rating here

At our previous inspection in October 2020 we rated the practice as requires improvement for providing well-led services. This was because;

- The practice did not have clear and effective processes for managing risks, issues and performance.
- There was limited evidence that the practice involved the public, staff and external partners to sustain high quality and sustainable care.

At this inspection we found the practice had made significant improvements.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: The practice had identified that there were gaps in their leadership and management arrangements that needed addressing. To provide the necessary guidance and leadership the practice had engaged the services of three very experienced former practice managers on a part-time basis to assist in their transformation. One of those had been appointed to the role of Executive Manager to provide oversight and report directly to the partners. The partnership had reduced to four GP partners from a high of 12 at one point. The Partners told us that the reduced size of the partnership provided for quicker, clearer decision making in key operational and management areas.  Recruitment of GPs and clinical staff has been and remains very difficult in this area.	

### Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes

## 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.	Partial (1)
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.	Partial (2)
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: (1) Our own feedback from staff of which there were 29 responses from 68 who were invited to take part showed mixed views. Clinical staff who responded, overwhelming said that they felt able to raise concerns and that the practice encouraged candour, openness and honesty, whereas several non-clinical members of staff who had responded did not share that view. We raised this with the partners who were aware of some issues and we were assured that action was ongoing to ensure all staff felt confident in their ability to speak up.	

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

Source	Feedback
CQC feedback form	I think the practice looks after staff very well. They are very accommodating.
CQC feedback form	We are a good practice
CQC feedback form	The new phone system is a great success. Not so many irate patients.
CQC feedback form	We work really well and are helpful to everyone and try our best.



CQC feedback form	Some sites don't answer their phones. This needs to be addressed as it makes work harder and time wasted.
CQC feedback form	(Referring to support from GPs) Not always. Conflicting messages from them at times. Some GPs more approachable than others.
CQC feedback form	I have seen the service change over the past X yrs. (number redacted to protect identity of the respondent) and not all for the better. I accept that the management and partners are working hard to address the issues identified in the CQC inspection. However, issues around staff morale, support and availability are still an issue.
CQC feedback form	The staff could be better supported. Management could be more visible.

## 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

## Managing risks, issues and performance

**There were clear and effective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	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

Explanation of any answers and additional evidence:

The practice had taken positive action to ensure they were aware of telephony performance in real time. This had enabled the system to be re-configured, more lines opened, and staff deployed in a way that best suited demand, both at peak and other times. For example, the number of abandoned calls in January 2021 had been 8563 or 48% of the total received. In July 2021 this had reduced to just 979 or 7% of calls received. The longest wait time for calls after 9am in January 2021 had been 57mins and 38 seconds. This had steadily reduced to the longest wait time being 11 minutes and 56 seconds in

July. The average wait times for calls both before and after 9am had better than halved in the same period.

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes

**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
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

**Governance and oversight of remote services**

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes

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

### **Engagement with patients, the public, staff and external partners**

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes

Feedback from Patient Participation Group.

<b>Feedback</b>
We spoke with the Chair of the PPG. They told us that the practice was keen for the PPG to develop and be more active as it emerges from the Covid pandemic. New members willing to sit on the committee had been identified and plans were in progress to recruit younger members. They told us that the experience of people getting in contact with the practice by telephone had dramatically improved, with significant decreases in waiting times for the phones to be answered. They told us that overall, they thought the practice had much improved.

### **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

## Examples of continuous learning and improvement

The practice is a training practice and runs teaching sessions for GP Registrars to discuss clinical guidelines. Succession planning has been considered as one GP has become a GP Trainer so the practice can continue to be a training practice when the current GP trainer retires.

Case-based discussions at clinical meetings are used to share learning.

Teaching sessions were held in response to learning events or requests from staff. A teaching session on thyroid problems had been held as the clinical practitioners wanted to improve their understanding of thyroid function test results.

The practice is involved in work with the Primary Care Network including:

- A Care Home project to support patients in care homes.
- Streamlining and improving safeguarding processes.
- Providing more support for patients with mental health problems and learning disabilities.

A former GP Registrar is becoming a salaried GP, and another has expressed an interest in doing so.

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.
- 
- ‰ = per thousand.