

Care Quality Commission

Inspection Evidence Table

Weoley Park Surgery (1-542229636)

Inspection date: 25 July 2022

Date of data download: 18 July 2022

Overall rating: Good

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 |
|--|-------------|
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Y |
| Partners and staff were trained to appropriate levels for their role. | Y |
| There was active and appropriate engagement in local safeguarding processes. | Y |
| The Out of Hours service was informed of relevant safeguarding information. | Y |
| There were systems to identify vulnerable patients on record. | Y |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Y |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had developed effective systems for safeguarding children and vulnerable adults.• The practice had a clinical and an administrative lead for safeguarding children and vulnerable adults.• Safeguarding policies were in place to support staff. These included contact information for relevant agencies involved in investigating safeguarding concerns.• Safeguarding meetings were held every two months to discuss the practices most vulnerable patients and identify any action needed. Health Visitors and District Nurses were invited but were not always able to attend meetings, staff told us that they maintained contact with them through other means. | |

| Safeguarding | Y/N/Partial |
|---|-------------|
| <ul style="list-style-type: none"> We saw system alerts were used so that staff were aware of any patients who might be at risk. Training records seen showed staff were trained to an appropriate level for their roles and responsibilities. The practice was an IRIS trained practice, IRIS is a local service providing support to those at risk of domestic abuse. The practice told us that all staff underwent DBS checks. | |

| Recruitment systems | Y/N/Partial |
|---|-------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Y |
| Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We reviewed recruitment files for two members of the staff team and found appropriate checks in place. The practice manager told us that they monitored clinical staff registration with their professional bodies on a monthly basis however, these were not formally recorded to show they had been done. All staff completed a self-declaration of their immunity. | |

| Safety systems and records | Y/N/Partial |
|---|-------------|
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 4 March 2022 | Y |
| There was a fire procedure. | Y |
| Date of fire risk assessment: 11 August 2021 (Weoley Park Surgery) and 9 September 2021 (Grange Hill Surgery) | Y |
| Actions from fire risk assessment were identified and completed. | |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Both the main and branch site had recently undergone refurbishment and were well maintained. We saw that equipment was also regularly serviced and maintained. This included portable appliance testing and calibration checks of clinical equipment. We also saw records which showed servicing of fire equipment and alarms. Staff received fire safety training and two members of the team were nominated fire marshals. The practice undertook regular fire drills to ensure staff knew what to do. Records showed these had been done four times during the last 12 months. Staff told us that they tested the alarms on a weekly basis but did not maintain records of this. | |

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. | Y |
| Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 21 April 22 (Weoley Park Surgery) and 9 May 22 (Grange Hill Surgery) | Y |
| The practice had acted on any issues identified in infection prevention and control audits. | Partial |
| The arrangements for managing waste and clinical specimens kept people safe. | Y |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had a named lead for infection prevention and control (IPC). • IPC policies were accessible to staff. • Records showed that staff received IPC training. • We found the premises visibly clean and tidy. Cleaning was carried out by an external company who had carried out audits of the cleaning. • Staff had access to personal, protective equipment and wipes for cleaning rooms between patients. Records were maintained for the cleaning of specific clinical equipment. • We saw that there had been recent audits undertaken at both the main and branch practice site, both had scored 100%. However, we noticed that a non-wipeable chairs in the isolation room had not been picked up in the audit. Staff told us that the room was rarely used. • There were appropriate arrangements in place for the removal of clinical waste, including sharps. • Staff we spoke with were able to describe how they safely handled any clinical specimens. Spill kits were available for the safe cleaning of any bodily fluid spills. | |

Risks to patients

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

| | Y/N/Partial |
|---|-------------|
| There was an effective approach to managing staff absences and busy periods. | Y |
| There was an effective induction system for temporary staff tailored to their role. | Y |
| The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures. | Y |
| Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients. | Y |
| There were enough staff to provide appointments and prevent staff from working excessive hours | Y |
| <p>Explanation of any answers and additional evidence:</p> | |

- Staff we spoke with felt their workloads were manageable and were able to accommodate appointments for patients. The national GP patient survey showed patients responses to questions about access were above local averages and in most cases above national averages.
- There was an induction pack available for new staff and locums with key information to support them while working at the practice.
- Staff records seen showed that staff received basic life support and sepsis training. Reception staff told us that if they had any any concerns about a patient they could speak to the on-call doctor or if necessary, advise the patient to call 999.

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. | Y |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Y |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | Y |
| Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals. | Y |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Y |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | N/A |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Our review of clinical records found that they were well maintained and patient information, such as test results, were dealt with in a timely manner by clinical staff.• Referral letters seen contained relevant information. | |

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) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA) | 0.73 | 0.79 | 0.79 | 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). (01/04/2021 to 31/03/2022) (NHSBSA) | 6.1% | 8.1% | 8.8% | 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 (01/10/2021 to 31/03/2022) (NHSBSA) | 5.23 | 5.19 | 5.29 | No statistical variation |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA) | 110.8‰ | 113.4‰ | 128.2‰ | No statistical variation |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA) | 0.55 | 0.62 | 0.60 | No statistical variation |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA) | 4.8‰ | 7.7‰ | 6.8‰ | No statistical variation |

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

| Medicines management | Y/N/Partial |
|---|-------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Y |
| Blank prescriptions were kept securely, and their use monitored in line with national guidance. | Y |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Y |

| Medicines management | Y/N/Partial |
|--|-------------|
| 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. | Y |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. | Y |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | Y |
| 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. | Y |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Y |
| There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer. | Y |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | N/A |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Y |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Y |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Y |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Y |
| Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective. | Y |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Nationally reported prescribing data showed that prescribing was in line with local and national averages. The practice participated in prescribing audits led by the former Clinical Commissioning Group, these included audits of antibiotic and hypnotic prescribing. We found medicines, vaccines and prescription stationery were appropriately stored and monitored during our onsite visit. Staff we spoke with understood the importance of maintaining the cold chain for vaccines. We saw that audits were undertaken for non-medical prescribers which included a review of their prescribing. The practice had access to a pharmacist through their primary care network. The pharmacist supported the practice with medicine reviews and queries. The practice held emergency medicines and equipment at both their main and branch practice. They were accessible to staff when needed and monitored regularly to ensure they were in date and fit for use. The practice held most recommended emergency medicines and were able to | |

articulate their rationale where one was not routinely stocked. The risk assessment was forwarded to us following the inspection.

- As part of our inspection we reviewed the management of patients on high risk medicines that require regular blood tests and monitoring due to the risk of significant side effects. Our searches found patients on Disease-Modifying Antirheumatic Drugs (DMARDs), Direct-Acting Oral Anticoagulant (DOACs), Warfarin and Lithium were all up to date with monitoring.
- We identified 55 patients out of 716 patients prescribed ACE inhibitors or Angiotensin II receptor blockers (used to treat high blood pressure) that were not up to date with monitoring, we randomly looked at five of these patients and found that the patients had been recalled by the practice for their monitoring review but failed to respond.
- We found a small number of patients (four) who were on high numbers of short-acting inhalers for their asthma, all had received appropriate review with the exception of one patient who had been recalled by the practice but failed to respond.

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. | Y |
| Staff knew how to identify and report concerns, safety incidents and near misses. | Y |
| There was a system for recording and acting on significant events. | Y |
| Staff understood how to raise concerns and report incidents both internally and externally. | Y |
| There was evidence of learning and dissemination of information. | Y |
| Number of events recorded in last 12 months: | 5 |
| Number of events that required action: | 5 |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had an incident policy in place for reporting and sharing incidents. • Staff we spoke with were aware of the systems and processes for reporting incidents and were able to share examples with us. • We saw that incidents were discussed as a standing agenda items at practice meetings to share learning. | |

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

| Event | Specific action taken |
|---|--|
| Delay in responding to a call from a District Nurse in relation to a patient's ReSPECT form. (The ReSPECT form sets out personalised recommendations in conjunction with the patient, their families and healthcare professionals for clinical care and treatment in a future emergency when the patient may be unable to express their choices). | <p>Staff were reminded to speak to clinician if urgent and ensure they record the contact details of the person calling. Processes around RESPECT forms were reviewed and updated to minimise the risk of this happening again. This included, staff recording on record who has collected the form and where it is going to be stored in the patients home so that it is accessible to healthcare staff, when needed. Where a patient is under the District Nursing team a copy of the form is to be sent to them.</p> <p>The incident was discussed and shared with staff at a practice meeting.</p> |
| The medicine fridge was switched off during refurbishment of the practice, leading to the loss of vaccines. | <p>The practice contacted the manufacturer for the vaccines who advised that they should be discarded. The fridge switch was taped over and a note placed by the socket as a reminder not to turn off. Data loggers were purchased to provide back up for recording fridge temperatures.</p> <p>The incident was discussed and shared with staff at a practice meeting.</p> |

| Safety alerts | Y/N/Partial |
|--|-------------|
| There was a system for recording and acting on safety alerts. | Y |
| Staff understood how to deal with alerts. | Y |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a lead clinician who received and shared relevant safety alerts with the practice team. These were then discussed at the practice meetings, as a standing agenda item to identify any actions needed. • As part of the inspection we reviewed the management of a Medicines and Healthcare products Regulatory Agency (MHRA) alert. The alert related to potential risks associated with specific medicines used in the management of diabetes. We found 93 patients prescribed these medicines, we reviewed five of the patients' records at random and found appropriate management and discussions had taken place with the patients about the potential risks. | |

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.

Effective needs assessment, care and treatment

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

| | Y/N/Partial |
|---|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | Y |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Y |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | Y |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Y |
| Patients' treatment was regularly reviewed and updated. | Y |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Y |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Y |
| The practice had prioritised care for their most clinically vulnerable patients during the pandemic | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice was a teaching practice and staff told us that there was a strong ethos for learning and development.• The practice held weekly clinical meetings in which staff shared presentations on various clinical issues.• With delays in secondary care referrals due to the pandemic, clinical staff made use of advice and guidance to support their patients while waiting to be seen by a specialist.• The practice made use of templates to ensure consistency in the management of patients with long term conditions.• Clinical staff told us that they followed up on all patients with unplanned admissions.• We saw clinical audits that reviewed practice performance against evidence-based guidance such as the National Institute for Health and Care Excellence (NICE). | |

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 meningitis vaccine was available for eligible patients, for example those attending University for the first time on request.
- 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. During 2021/22 financial year the practice advised us that they had carried out 155 NHS health checks.
- All patients with a learning disability were offered an annual health check. The practice advised that they had completed learning disability health checks on 91% of the patients on their learning disability register.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Regular Gold Standard Framework meetings were held to discuss patients on their palliative care register.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice signposted patients who misused substances to appropriate services available locally.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services. Practice staff told us that they were due to be supported by a Mental Health worker next month through their primary care network.

Management of people with long term conditions

Findings

- As part of our inspection we reviewed the records of a sample of patients with various long-term conditions and found appropriate management in place. For example:

We reviewed the records for five patients with potentially poorly controlled asthma that had been issued two or more rescue steroids in the last 12 months. All had received appropriate follow up, however we were unable to determine whether patients had been issued a steroid card, where appropriate. Clinical staff we spoke told us they did issue them but did not record this on the clinical system. We saw steroid cards were available in the clinical rooms during our site visit.

We reviewed the records of three patients with late stage Chronic Kidney disease and found the patients were being appropriately follow under secondary care.

There was a small percentage (5%) of patients with hypothyroidism who had not had monitoring in last 18 months. We reviewed five of these records and found three patients whose monitoring was overdue. Two of these patients had been stable on their medication and clinical staff advised that they had been a lower priority during the pandemic, the other patient's thyroid blood monitoring had been inadvertently missed during other recent blood tests. Clinical staff advised these would be picked up as part of their routine weekly recall searches.

We reviewed the records of five patients with potentially poorly controlled diabetes, all but one had been reviewed. The practice was aware of the patient who had not responded to recalls and told us they would be following the patient up.

We found six patients with a potential of a missed diabetes diagnosis based on their diabetic blood test readings. We reviewed the records for five of these patients, we found three were appropriately coded and followed up. The practice was aware of the two remaining patients, who had failed to respond to recalls.

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. The practice ran weekly searches and held weekly Quality Outcome Framework Meetings (QOF) so that they could discuss and prioritise patients due for a review.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice 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 appropriate medicines.
- Patients with suspected hypertension were able to loan a blood pressure monitor from the practice to undertake home blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

| Child Immunisation | Numerator | Denominator | Practice % | Comparison to WHO target of 95% |
|--|-----------|-------------|------------|---------------------------------|
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 59 | 68 | 86.8% | Below 90% minimum |

| | | | | |
|--|----|----|-------|------------------|
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 77 | 84 | 91.7% | Met 90% minimum |
| The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 77 | 84 | 91.7% | Met 90% minimum |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 76 | 84 | 90.5% | Met 90% minimum |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 65 | 84 | 77.4% | Below 80% uptake |

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

Any additional evidence or comments

- The practice was not meeting the WHO based uptake target of 95% for childhood immunisations (the recommended standard for achieving herd immunity) for any of the childhood immunisation indicators and was below the minimum 90% uptake target for those administered at age one and five.
- Data trends showed an improvement on the previous year for all immunisations except those given at age one.
- Staff told us that they ran weekly searches of patients due to receive their immunisations and discussed these at their weekly QOF meetings. There was a nominated member of the administrative team who was given protected time to contact and recall patients for immunisations. Patients were called the day before the appointment and any patients that did not attend were contacted to find out why.
- Following the inspection, the practice shared with us their child health vaccination data they had submitted during 2021/22. This preliminary data showed general improvements in the child immunisation data at ages one and five.

| Cancer Indicators | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency) | 66.3% | N/A | 80% Target | Below 70% uptake |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA) | 42.3% | 52.8% | 61.3% | N/A |
| Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA) | 57.6% | 55.6% | 66.8% | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA) | 58.6% | 52.9% | 55.4% | No statistical variation |

Any additional evidence or comments

- Uptake of cervical screening was below the 80% national target. Data trends in uptake showed little change over time.
- The practice operated a similar system as for child immunisations in which they ran weekly searches of patients that were due for cervical screening. Patients were contacted before their appointment to encourage attendance and again if they did not attend to discuss the reasons why.
- Following the inspection the practice forwarded to us information relating to the uptake of cervical screening taken from the Quality and Outcomes Framework (QOF). This showed a QOF score of 73% uptake. QOF data differs to the Public Health England (PHE) data in that it takes into account exceptions, whereas the PHE shows the actual numbers screened.
- Uptake of breast cancer screening was below local and national averages. While uptake of bowel cancer screening was similar to local averages but below the national averages. Practice staff told us that they would follow patients up as they got notified when patients failed to attend national screening.

Monitoring care and treatment

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

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

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

| |
|--|
| <p>The practice shared with us some of the clinical audits they had undertaken, these included:</p> <ul style="list-style-type: none">• An audit of a medicine used in the treatment for weight loss. The practice compared prescribing and management of the medicine against NICE guidance. The first audit of 27 patients prescribed the medicine between September 2019 and September 2020 found areas for improvement against standards set for example, recording of patients Body Mass Index and weight and counselling on the weight loss required to continue treatment. The second audit of 18 patients identified between September 2020 and September 2021, showed significant improvement with all original standards set had been met.• A quality improvement project undertaken in November 2021 reviewed the management of patients with Vitamin B12 deficiency. The practice identified patients who were receiving Vitamin B12 via injections which required several visits to the practice in a short period of time and potential exposure during the pandemic of unnecessary coronavirus contact. Of the 25 patients identified the practice found nine of the patients could be managed differently reducing the need to attend the practice as frequently.• A Heart Failure audit looked at prescribing of patients with a new diagnosis in line with best practice guidelines. The practice identified 12 newly diagnosed patients between December 2019 and December 21. The practice identified areas for improvement in the follow up of these medicines. The results were presented at a practice meeting to raise awareness among clinical staff. |
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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. | Y |
| The practice had a programme of learning and development. | Y |
| Staff had protected time for learning and development. | Y |
| There was an induction programme for new staff. | Y |
| Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation. | Y |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | Y |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Y |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The provider had identified mandatory training requirements for all staff and we saw good uptake of this training. • There was a planned induction programme for new staff and regular appraisals for all staff where they could discuss any training and development needs. We saw examples of completed induction programmes and appraisals. • Staff we spoke told us that the practice was very supportive of learning and development and were given protected time and funding for training. • Competencies of staff in advanced roles were assured through regular audits of their work. The staff were allocated a GP supervisor and protected time was allocated for them to go through consultations. | |

Coordinating care and treatment

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

| Indicator | Y/N/Partial |
|---|-------------|
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Y |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Y |
| Explanation of any answers and additional evidence: | |

- The practice held regular meetings in which they invited community and social care staff to discuss the needs of some of their most vulnerable patients. Where the community teams were not able to attend, regular communication was made directly by email or phone.
- The practice was part of a local GP federation in which they could access additional services for their patients.

Helping patients to live healthier lives

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

| | Y/N/Partial |
|---|-------------|
| The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers. | Y |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health. | Y |
| Patients had access to appropriate health assessments and checks. | Y |
| Staff discussed changes to care or treatment with patients and their carers as necessary. | Y |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity. | Y |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice offered NHS health checks to patients to help identify potential health conditions and provide health and lifestyle support. • Patients needing support with smoking cessation and weight management were signposted to local services available. • Patients at risk of developing diabetes were referred to the National Diabetes Prevention Programme. • A social prescriber attended the practice on a weekly basis to provide patients with general wellbeing support. • Patients with anxiety and depression could access local counselling services. The practice also told us that they were shortly due to have a mental health worker aligned to the practice through their primary care network arrangements. • The practice was part of a community pharmacist scheme where they could refer patients to participating pharmacists for support on minor ailments for example, insect bites. | |

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. | Y |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | Y |

| | |
|--|---|
| Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. | Y |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none">• Staff had access to consent policies and guidance which referenced the Mental Capacity Act, Deprivation of Liberty Safeguards (DoLS) and consent relating to children.• The practice undertook minor surgery and we saw an example of a completed consent form and saw that the patient had opportunities to discuss the risks and benefits of the procedure.• As part of the inspection we reviewed a sample of three DNACPR decisions and found these had been completed appropriately. | |

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. | Y |
| Staff displayed understanding and a non-judgemental attitude towards patients. | Y |
| Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">Feedback from patients was positive about the way they were treated. | |

| Patient feedback | |
|------------------|---|
| Source | Feedback |
| Patient feedback | Patient feedback received told us that patients were treated with respect; staff were pleasant and that they would recommend the service to others. |
| NHS Website | Of the eight reviews posted in the last 12 months five were positive about the staff and service received. Staff were described as helpful, professional and caring. Negative comments related to access. |

National GP Patient 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) | 91.3% | 86.6% | 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) | 90.9% | 85.3% | 88.4% | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021) | 97.0% | 94.4% | 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) | 88.2% | 78.3% | 83.0% | No statistical variation |

Any additional evidence or comments

- Results from the GP National Patient Survey (published in July 2021) were higher than local and national averages for questions about the patient experience.

Question

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

Any additional evidence

The practice shared with us the results of a recent in-house patient survey they had undertaken in January 2022. The practice received 98 responses from 133 shared. Results showed:

- 78% of patients who responded felt they were treated with care and concern
- 87% said their overall experience of the surgery was good or very good.

The practice had reviewed patient feedback to identify any actions needed. Actions taken had largely focused on access.

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. | Y |
| Staff helped patients and their carers find further information and access community and advocacy services. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Results from the GP National Patient Survey (published in July 2021) were above local and national averages for questions about involvement in decisions. Patients requiring additional support could be referred to the social prescriber. | |

| Source | Feedback |
|------------------|---|
| Patient Feedback | Feedback received from patients indicated they were involved in discussions about care and treatment. |

National GP Patient 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) | 94.1% | 89.9% | 92.9% | No statistical variation |

| | Y/N/Partial |
|--|-------------|
| Interpretation services were available for patients who did not have English as a first language. | Y |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | Partial |
| Information leaflets were available in other languages and in easy read format. | Partial |
| Information about support groups was available on the practice website. | Y |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was limited information displayed in the practice about support groups and organisations, however, information was available through the practice website. Staff were also aware of local services including the social prescriber that they could refer patients to. • The practice website had an accessibility option in which patients could adjust the setting for their needs for example, larger font and dyslexia friendly text. | |

| Carers | Narrative |
|---|---|
| Percentage and number of carers identified. | The practice had identified 236 patients as carers (approximately 3% of the practice list size). |
| How the practice supported carers (including young carers). | Staff told us that they would try to be flexible with appointments for patients with caring responsibilities and would provide home visits if needed. Carers were offered a referral to the social prescriber for support and access to flu vaccinations and health checks. Links to carer support was available on the practice website. |
| How the practice supported recently bereaved patients. | Staff told us that they sent a condolence letter with information about support available to bereaved patients and would follow up with a call. |

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. | Y |
| There were arrangements to ensure confidentiality at the reception desk. | Y |
| <ul style="list-style-type: none"> • Reception staff were aware that they could take patients to a room available if the patient wished to discuss something in private. • Privacy curtains were available in clinical rooms. | |

- Staff signed confidentiality agreements as part of their employment and received training in information governance.

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. | Y |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided. | Y |
| The facilities and premises were appropriate for the services being delivered. | Y |
| The practice made reasonable adjustments when patients found it hard to access services. | Y |
| There were arrangements in place for people who need translation services. | Y |
| The practice complied with the Accessible Information Standard. | Y |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice was accessible to patients with mobility difficulties and those with pushchairs. • The premises included facilities and parking for disabled persons and baby changing facilities. • Interpreting services were available if needed and some staff spoke second languages. • The practice could provide information in various formats on request. • There was a hearing loop for those who were hard of hearing. • Home visiting was available for those that were housebound. | |

| Practice Opening Times | |
|------------------------|---|
| Day | Time |
| Opening times: | |
| Monday | 8am to 6.30pm |
| Tuesday | 8am to 6.30pm |
| Wednesday | 8am to 6.30pm (branch site closes at 1pm) |
| Thursday | 8am to 6.30pm |
| Friday | 8am to 6.30pm |
| | 8am to 6.30pm |
| Monday | Appointments available throughout opening hours |
| Tuesday | Appointments available throughout opening hours |
| Wednesday | Appointments available throughout opening hours |
| Thursday | Appointments available throughout opening hours |

| | |
|---|--|
| Friday | Appointments available throughout opening hours |
| | |
| Extended access appointments (by appointment) | <p>In house extended access appointment were available Monday to Friday between 6.30pm and 7.15pm</p> <p>Extended access appointment at College Green Medical Practice were available: Monday to Friday 6.30pm to 8pm and Saturday 9am to 1pm</p> |

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and provided home visits and urgent appointments, if needed for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was able to offer extended access appointments in the evenings and at the weekends to support those who worked.
- The practice held a register of patients living in vulnerable circumstances such as those with a learning disability or at risk of harm.
- Staff told us the practice was a Safe Surgery which aimed to reduce barriers for people in vulnerable circumstances for example, those with no fixed abode and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

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

| | Y/N/Partial |
|--|-------------|
| Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice | Y |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online) | Y |
| Patients were able to make appointments in a way which met their needs | Y |
| There were systems in place to support patients who face communication barriers to access treatment | Y |
| Patients with most urgent needs had their care and treatment prioritised | Y |
| There was information available for patients to support them to understand how to access services (including on websites and telephone messages) | Y |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Patients could access appointments by telephone, in person or via the practice website. • Patients were asked for the reason for their appointment so they could be booked in with the most appropriate clinician for their needs. • The practice had made adjustments to their appointment system based on patient feedback to accommodate individual preferences for face to face and telephone consultations. The practices own patient survey in January 2022 found that 58% of patients wanted a telephone consultation over a face to face appointment. • Reception staff were given guidance on appointments that were not appropriate for a telephone consultation so that they could be booked in as a face to face. • In addition to extended access appointments, patients could sign up to a GP video consultation service which was available in the evenings and at weekends. • For some minor ailments patients could be referred to the Acute Pharmacy Consultation service run by local pharmacies. | |

National GP Patient 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) | 87.1% | N/A | 67.6% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021) | 81.6% | 62.5% | 70.6% | 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 (01/01/2021 to 31/03/2021) | 69.2% | 61.6% | 67.0% | No statistical variation |
| The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021) | 77.0% | 76.8% | 81.7% | No statistical variation |

Any additional evidence or comments

- Results from the GP National Patient Survey (published in July 2021) showed responses to questions about access were above local averages and above national averages for questions about ease of getting through on the phone and experience of making an appointment.
- The practice's in-house survey found 84% of patients who responded were happy with the available appointment times.

| Source | Feedback |
|-------------|---|
| NHS Website | Patient reviews were mostly positive about the service, there were a small number of reviews who were unhappy with access and time taken for telephone call backs from a clinician. |

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. | 30 |
| Number of complaints we examined. | 2 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 2 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | 0 |

| | Y/N/Partial |
|---|-------------|
| Information about how to complain was readily available. | Y |
| There was evidence that complaints were used to drive continuous improvement. | Y |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had a nominated lead and a procedure in place which set out the expectations for managing complaints. • Information was available to patients from reception or the practice website about how to raise a complaint. • The practice recorded and responded to both verbal and written complaints. • We reviewed two complaints that had been received in the last 12 months and found these had been responded to in a timely manner. Patients were also informed as to how they could escalate their concerns if they were unhappy with the response received. • Complaints were discussed as a standard agenda item at practice meetings to support learning. | |

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|--|--|
| Patient unhappy with the number of tests received. | Concerns discussed with the clinician involved and apology given. |
| Delayed referral. | Incident investigated and apology given. Discussed at the practice meeting to identify learning. |

Well-led

Rating: Good

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. | Y |
| They had identified the actions necessary to address these challenges. | Y |
| Staff reported that leaders were visible and approachable. | Y |
| There was a leadership development programme, including a succession plan. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Leaders were aware of the challenges they faced in delivering the service, this mainly included access and waiting times for referrals to secondary care. They also shared with us actions taken to address these challenges.• The practice was part of a GP federation and a Primary Care Network enabling them to access wider support for their patients.• Staff we spoke with told us that the leadership of the practice (both clinical and managerial) were very visible and approachable. | |

Vision and strategy

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

| | Y/N/Partial |
|--|-------------|
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Y |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Y |
| Progress against delivery of the strategy was monitored. | Y |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice shared with us their Business Development Plan which set out their vision for the future. This was consistent with what we were told and saw during our inspection. | |

Culture

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

| | Y/N/Partial |
|---|-------------|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | Y |
| Staff reported that they felt able to raise concerns without fear of retribution. | Y |
| There was a strong emphasis on the safety and well-being of staff. | Y |
| There were systems to ensure compliance with the requirements of the duty of candour. | Y |
| When people were affected by things that went wrong, they were given an apology and informed of any resulting action. | Y |
| The practice encouraged candour, openness and honesty. | Y |
| The practice had access to a Freedom to Speak Up Guardian. | Y |
| Staff had undertaken equality and diversity training. | Y |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff were very positive about the culture of the practice. Staff felt able to raise concerns or feedback and told us that there was a no blame culture and strong emphasis on staff wellbeing. The practice regularly held social events for their staff. • The practice had a Freedom to Speak Up Guardian and knew who this was if they wanted to raise anything. • Staff were aware of duty of candour and were able to give an example as to how this had been implemented. | |

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

| Source | Feedback |
|----------------|---|
| Staff feedback | Staff we spoke with and received written feedback from described a very inclusive culture at the practice. They were very complimentary about the leadership and told us that they felt well supported in terms of both their wellbeing and roles. They told us that the practice was a happy and friendly place to work. |

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. | Y |
| Staff were clear about their roles and responsibilities. | Y |

| | |
|---|---|
| There were appropriate governance arrangements with third parties. | Y |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none">• Staff had access to policies and procedures that were regularly updated.• There were comprehensive meeting structures in place that were inclusive of all staff and ensured important information was shared throughout the practice team. Minutes of meetings were available for those who were unable to attend. | |

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. | Y |
| There were processes to manage performance. | Y |
| There was a quality improvement programme in place. | Y |
| There were effective arrangements for identifying, managing and mitigating risks. | Y |
| A major incident plan was in place. | Y |
| Staff were trained in preparation for major incidents. | Y |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Y |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • The practice held weekly business meetings where they discussed clinical performance and identified where they needed to focus. • Performance and risks were regularly discussed with staff at the various practice meetings • The practice had a Disaster Handling and Business Continuity Plan which set out the arrangements in the event of a disruption to the running of the service. | |

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

Explanation of any answers and additional evidence:

- The practice had reviewed their appointment systems throughout the pandemic and taken into account patient preferences when doing so. This enabled them to meet the needs of those who might be digitally excluded and those who had work commitments, while still ensuring those who needed a face to face appointment received one.
- The practice put in place systems to identify and prioritise patients who were most at risk during the pandemic. They undertook weekly searches to follow up patients with long term conditions and manage any backlogs caused by the pandemic.
- Additional infection prevention and control measures had been put in place to maintain staff and patient safety during the pandemic.

Appropriate and accurate information

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

| | Y/N/Partial |
|--|-------------|
| Staff used data to monitor and improve performance. | Y |
| Performance information was used to hold staff and management to account. | Y |
| Staff whose responsibilities included making statutory notifications understood what this entailed. | Y |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> Weekly meetings and discussions around clinical performance enabled staff to monitor progress against national and local targets and standards and take action where needed. | |

Governance and oversight of remote services

| | Y/N/Partial |
|--|-------------|
| The practice used digital services securely and effectively and conformed to relevant digital and information security standards. | Y |
| The provider was registered as a data controller with the Information Commissioner's Office. | Y |
| Patient records were held in line with guidance and requirements. | Y |
| Patients were informed and consent obtained if interactions were recorded. | Y |
| The practice ensured patients were informed how their records were stored and managed. | Y |
| Patients were made aware of the information sharing protocol before online services were delivered. | Y |
| The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services. | Y |
| Online consultations took place in appropriate environments to ensure confidentiality. | Y |
| The practice advised patients on how to protect their online information. | Y |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> Staff had access to secure systems if they needed to work remotely but preferred to work onsite. Patients had to register with identification in order to use online services. They were given a secure password to enable them to access the service. Staff told us that remote consultations were not recorded. Information governance was part of the practice's mandatory training. | |

Engagement with patients, the public, staff and external partners

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

| | Y/N/Partial |
|--|-------------|
| Patient views were acted on to improve services and culture. | Y |
| The practice had an active Patient Participation Group. | Y |
| Staff views were reflected in the planning and delivery of services. | Y |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Y |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • The practice received scores through the National GP Patient Survey that were overall above local and national averages for questions relating to patient experience and access. • The practice obtained feedback from patients through their Patient Participation Group (PPG), patient surveys and their website. They had used this to influence the provision of appointments. • The practice had a stable PPG that were starting to meet up again following a hiatus during the pandemic. The PPG supported the practice in delivering patient surveys, they had also provided input into the practice refurbishment and told us how they had been able to influence service provision for example, the prescription ordering service. • Staff were able to raise ideas to improve service delivery through practice meetings and appraisals and were able to give an example of where their ideas had been implemented. • The practice worked with their local Primary Care Network in providing additional support to their patient population. | |

Feedback from Patient Participation Group.

| Feedback |
|--|
| During the inspection we spoke with the chair of the Patient Participation Group (PPG) who felt patients received a good service. They felt the PPG was valued in supporting the practice. |

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. | Y |
| Learning was shared effectively and used to make improvements. | Y |
| Explanation of any answers and additional evidence: | |

The practice had a very strong culture of learning and development. The practice was a teaching and training practice for medical students and qualified doctors training to become a GP. They also hosted Physician Associate Students from a local University. One of the partners was also a GP training programme director for Health Education England.

The partners had worked closely with their staff in advanced clinical roles to develop their skills and competencies. They had provided extensive supervision and learning opportunities to support them as valued members of the clinical team. This was in addition to the weekly clinical meetings which enabled staff to discuss and develop clinical learning.

Practice staff consistently spoke about the culture of the team, how they worked well together and how wellbeing was given high priority. This impacted positively on the delivery of patient care.

The practice undertook regular clinical audits to support service improvement.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a 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.