

Care Quality Commission

Inspection Evidence Table

Park View Surgery (1-10178239555)

Inspection date: 12 October 2021

Date of data download: 04 October 2021

Overall rating: Good

We inspected the practice on 20 August 2019 following our annual review of the information available to us and rated the practice requires improvement overall. We rated the practice as requires improvement for the delivery of well-led services because the leadership, governance and culture did not always support the delivery of high-quality person-centered care. Good for responsive services and we did not rate the practice for effective, due to limited evidence available to the Commission relating to this provider to make a judgement. The provider of this practice changed in May 2021 and inherited the previous inspection rating. We followed up the enforcement action with an announced comprehensive inspection on 12 October 2021.

We found that the practice had made some improvements in relation to the breaches in regulation including clinical audits and fire risk assessments. However, there was still no embedded process for significant events. We also identified other areas of concern as not all staff had completed mandatory training, there was no embedded process for complaints and the practice's systems for the appropriate and safe use of medicines and the management of medicine safety alerts required review.

The practice was rated as good overall, requires improvement for the safe key question. It was rated as good for the provision of effective and well led services and outstanding for caring and responsive services.

Safe

Rating: Requires improvement

At the inspection in August 2019, the practice maintained their rating of good for the provision of safe services. Following this inspection, it has been rated as requires improvement as not all staff had completed mandatory training, the practice's systems for the appropriate and safe use of medicines required review, there was no embedded process for significant events and the management of medicine safety alerts required review.

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
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in November 2015 we found:</p> <ul style="list-style-type: none"> The CQC recommended the practice reviewed the risk assessment for administration staff not requiring disclosure and barring service checks. This was followed up at the inspection in August 2019 and there was a process in place to address this. <p>At the inspection in October 2021 we found:</p> <ul style="list-style-type: none"> Four non-clinical members of staff had not had a DBS check. Although non-clinical staff do not act as chaperones the practice were in the process of obtaining DBS checks for those staff. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
Explanation of any answers and additional evidence:	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: August 2021	Y
There was a fire procedure. Date of fire risk assessment: November 2020	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	

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.	P
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: September 2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Two out of five non-clinical staff had not completed infection prevention and control (IPC) training. The practice were aware there were gaps in mandatory training prior to inspection. The practice were trying to encourage uptake by setting aside time/paying for staff's time or arranging lunch for the staff. Mandatory training was part of the practices action plan (submitted at the site visit), due to be completed in October 2021.	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice had designed an annual plan detailing how many appointments and staff were needed per week and year to meet the performance targets and patient outcomes. This included staff annual leave and sickness. This enabled the practice to effectively plan the appropriate appointments for patients. The practice aimed to offer 75 appointments per week per 1000 patients. In addition, the practice also had capacity for emergency and same day face to face appointments.	

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.	Y
Explanation of any answers and additional evidence:	

Appropriate and safe use of medicines

The practice's systems for the appropriate and safe use of medicines, required review.

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) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.76	0.72	0.69	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2020 to 30/06/2021) (NHSBSA)	6.7%	7.4%	10.0%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2021 to 30/06/2021) (NHSBSA)	4.60	5.36	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	78.1‰	160.1‰	126.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.24	0.41	0.65	Variation (positive)
(to) (NHSBSA)		-		-

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	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.	P
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.	P
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	NA
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	NA
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.	NA
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 PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>As part of our inspection, we undertook a remote search of the practice's clinical records system to assess the quality of care provided by the practice.</p> <ul style="list-style-type: none"> We reviewed medicine usage of asthma inhalers. Nine patients had been prescribed inhalers in the last 12 months. Of five patient records reviewed four patients had not received a review. We discussed this with the practice, and they agreed inhaler usage would be scrutinised through reviews and six-monthly audits and actioned within three months. This was included in the practices action plan, presented at the site visit. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> We also undertook a review of patients prescribed a high-risk drug (used as a blood thinner). 17 patients had been prescribed the medication. Of the five patients' records we reviewed, we saw three patients had not been informed of the potential risk and five patients had not received appropriate monitoring through a creatinine test. We discussed this with the practice, and they shared an action plan on the day of the site visit, which included inviting patients for a review within the next three months. After the inspection the practice confirmed the tests had been completed and seven patients were booked for appointments for blood tests. There was evidence of oversight of prescribing and monitoring of patients' health in relation to the use of Disease Modifying Antirheumatic Drugs (DMARD) which are used to treat inflammatory conditions. Four patients were prescribed the medication. We reviewed two records and saw patients had been monitored appropriately. One patient record didn't have an alert and the practice agreed to add the alert, run searches and ensure clarity regarding shared care agreements and blood monitoring if patients received this via secondary care. This was included in the practices action plan, presented on the site visit. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong, however they did not have an embedded process for significant events and the management of medicine safety alerts required review.

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.	P
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:	3
Number of events that required action:	3
Explanation of any answers and additional evidence: At the inspection in August 2019 we found: <ul style="list-style-type: none"> There was a lack of oversight of significant events as actions were not documented in two of the significant events we viewed. At the inspection in October 2021 we found: <ul style="list-style-type: none"> There was still a lack of oversight and documenting of significant events. The practice reported three significant events but were aware there had been more that had not been recorded. Staff provided examples of significant events and the learning, but these were not always documented. Learning from one verbal complaint we saw was to document the issue as a significant event, but there was no evidence of this. The practice were aware this was an issue prior to inspection and were keen to be proactive in documenting and embedding significant event analysis at the practice. This was included in their action plan (presented at the site visit). 	

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

Event	Specific action taken
Patients' blood pressure home monitoring sheet sent in via email from a shared email address. No name or date of birth on the form to confirm who the patient was.	Home blood pressure monitoring forms updated to include patients name and date of birth.
Transmissions of email error.	Staff involved in the transmission of emails will be reminded of General Data Protection Regulations (GDPR) and the necessary checks to protect patient confidentiality and privacy.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	P
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> All safety alerts go to the advanced nurse practitioner for dissemination to the appropriate staff and are printed and recorded when actioned. We saw examples of actions taken on recent alerts for example, the recall of Co-Codamol. As part of our inspection, we undertook a remote search of the practice's clinical records system to review the management of combination drug safety alerts, we found the practice did not routinely check historical alerts. We reviewed records of patients prescribed two medicines the alert recommended should not be prescribed together. Of the three patients records we reviewed, three had not been informed of the potential risk or received a review. Guidance states patients should be reviewed every six months. We discussed this with the practice, and they shared an action plan, which included inviting patients for a review, adding six monthly alerts to patients records and to audit every three months. Although the practice took safety alerts seriously, a further review of drug safety alerts was required to ensure all historic safety alerts had been acted on and to ensure future safety alerts were managed in a timely way. 	

Effective

Rating: Good

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

At the inspection in August 2019 we were unable to rate the practice for effective as we were unable to speak to any GPs, other than a locum GP before, during or after the inspection. This meant that despite practice performance and attainment data in this evidence table generally being comparable or better than local and national averages we were unable to seek confirmation that effective practices, monitoring arrangements and effective clinical leadership was in place.

At the inspection in October 2021 we were able to seek confirmation for the above.

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:	

Effective care for the practice population

Findings
<ul style="list-style-type: none"> • The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. • Health checks, including frailty assessments, were offered to patients over 75 years of age. • Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group. • The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. • Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. • All patients with a learning disability were offered an annual health check. • End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. • The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. • The practice demonstrated that they had a system to identify people who misused substances.

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- Patients with long term conditions were generally offered regular care reviews, for example patients with diabetes. However, we looked at five patient records and two patients had not received an asthma review and one out of four patients had not received a thyroid review. We discussed this with the practice, and they agreed to review the patients as a priority. This was included in their action plan presented at the site visit.
- 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 statins.
- Patients with suspected hypertension were offered ambulatory 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) (01/04/2019 to 31/03/2020) (NHS England)	21	23	91.3%	Met 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)	19	21	90.5%	Met 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)	19	21	90.5%	Met 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)	19	21	90.5%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	19	20	95.0%	Met 95% WHO based target

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 continued to meet performance target's during the covid pandemic. The practice had designed an annual plan to achieve patient outcomes and performance targets for disease management, such as childhood vaccinations and cervical screening. The plan detailed how many appointments and staff were needed per week and year to meet the performance targets. This included staff annual leave and sickness. This enabled the practice to effectively plan the appropriate appointments for patients. The practice aimed to offer 75 appointments per week for every 1000 patients registered with the practice. In addition, the practice also had capacity for emergency, triage and same day face to face appointments.

The practice had seen an increase of 120 patients registered with the practice within the last year, including an increase in babies and demand for immunisations. As a result, more appointments were made available to meet the needs of patient demand.

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: 31/03/2021) (Public Health England)	82.4%	N/A	80% Target	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	74.1%	71.6%	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)	66.2%	63.6%	63.8%	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) (PHE)	57.1%	43.8%	54.2%	No statistical variation

Any additional evidence or comments

At the last inspection in August 2019 the practice were below the 80% target (78.7%). At this inspection there had been a 4% improvement in the performance data for cervical screening.

The practice told us they proactively book patients for appointments and always ensure there are enough appointments. They also promoted the importance of cervical screening on social media and via text messages.

Monitoring care and treatment

The practice had a 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.	P
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

The practice had completed a one cycle audit for non-steroidal anti-inflammatory drugs. The audit confirmed all patients had received a medical review.

Any additional evidence or comments

At the inspection in August 2019 we found:

- Clinical audit activity was low, we saw evidence of a one cycle audit and a two-cycle audit. Audit activity was not scheduled in advance.

At the inspection in October 2021 we found:

- We saw evidence of three one cycle audits. The practice confirmed they would engage in more detailed audits about creatinine clearance calculation (this is a calculation done using the kidney blood test and patient weight and age), inhalers and blood tests for certain drug combinations. This will tie in well with the highlighted omissions in the clinical searches carried out as part of this inspection. The three audits were included in the practice's action plan (presented at the site visit).
- As part of an eight practice Primary Care Networks (PCN) there was constant benchmarking. Prescribing was scrutinised regularly with the support of the pharmacist.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	P
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
Explanation of any answers and additional evidence:	
At the inspection in August 2019 we found:	
<ul style="list-style-type: none"> The practice had a system in place to monitor staff training. All staff were up to date with training except for one staff member who was due to complete safeguarding training as a priority. Appraisals were inconsistent and not completed by an appropriate peer. 	
At the inspection in October 2021 we found:	
<ul style="list-style-type: none"> All staff were up to date with safeguarding training and to the appropriate level. However, there were gaps in other areas of mandatory training for mainly non-clinical staff, such as equality and diversity (six staff both clinical and non-clinical), conflict resolution (four staff both clinical and non-clinical) and infection prevention and control (two non-clinical staff). The practice were aware there were gaps in mandatory training prior to the inspection. The practice were trying to encourage uptake by setting aside time/paying for staff's time or arranging lunch for the staff. Mandatory training was part of the practices action plan (submitted at the site visit), due to be completed in October 2021. All training was reviewed at staff's annual appraisals. Staff confirmed they received regular supervisions, clinical peer support and annual appraisals. Appraisals and supervisions were conducted by the lead GP which provided governance oversight. They also mentored the pharmacist and had a close working relationship with them. Nurses were allocated time each day to discuss queries, guidance and learning. Staff told us they felt very supported. The staff survey in October 2021 showed 80% of staff felt supported during the pandemic and 20% of staff were satisfied with the support. The practice were part of the north primary care network and had access to a clinical pharmacist, a pharmacy technician, four care coordinators, a podiatrist and a dietician. The practice had a system in place to demonstrate the competence of staff employed in advanced clinical practice. 	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice held monthly care home multidisciplinary meetings, which were attended by staff from the practice, social services and from local care homes.Practice staff were involved in planning for the transition of children into adult services, particularly children with complex health needs.The frailty lead nurse arranged for patients and liaised with a geriatrician for domiciliary visits if required.The practice held monthly palliative care meetings with other voluntary organisations to discuss each patient's needs, including any patients who had recently received care from these services.	

Helping patients to live healthier lives

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

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

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y

Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence:</p> <p>As part of our inspection, we reviewed five completed DNACPR decision forms. In all five records, staff had recorded a clear rationale for the decision that was not discriminatory or based on assumptions about the person's quality of life. There was a clear record of a discussion taking place with the person and/or their family and there had been an assessment or decision made about the mental capacity.</p>	

Caring

Rating: Outstanding

When we inspected the practice in August 2019, we rated the practice as good for providing caring services. At the inspection in October 2021 we found the provider was providing an outstanding caring service as they had:

- Achieved positive patient experience results (GP Patient Survey) throughout the pandemic and demonstrated continued improvement since the last inspection in August 2019 in all indicators.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Most staff had worked at the practice for a long time and knew the patients well. Staff told us they were part of a good team and were dedicated and caring to give the best possible care to patients whilst maintaining a high level of care. As part of our inspection process, we conducted a remote review of patients' records. We saw staff treated patients with respect and compassion and saw no evidence of discrimination when decisions were made. Patients were signposted to appropriate supporting services where appropriate. The practice also had a system in place to support patients in domestic abuse. 	

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)	95.6%	87.0%	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)	97.2%	86.6%	88.4%	Tending towards variation (positive)
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)	95.7%	93.6%	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)	91.7%	78.0%	83.0%	No statistical variation

Any additional evidence or comments

The practice were notably above local and national indicators for patient experience and satisfaction.

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

Any additional evidence

The practice had achieved positive patient experience results throughout the pandemic and demonstrated continued improvement since the last inspection in August 2019 on all indicators. For example, the percentage of respondents who stated the healthcare professional was good or very good at listening to them had increased from 92% in the March 2019 survey to 95% in the March 2021 survey, and the percentage of respondents who stated the healthcare professional was good or very good at treating them with care and concern increased from 91% to 97% during the same period. The percentage of respondents who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to increase from 94% in the March 2020 survey to 95% in the March 2021 survey. There was a small reduction in the percentage of respondents who responded positively to their overall experience from 92% to 91% during this period.

The practice were rated the best GP practice out of 15 in Doncaster (GP patient survey September 2021 on behalf of NHSE) and this was published in Doncaster media. 327 survey forms were sent out to

patients with a 34% response rate. 75% said their experience was very good and 15% said it was fairly good.

The lead GP was awarded star of the month by Doncaster Clinical Commissioning Group (CCG) as he went above and beyond to meet patient's needs, very rarely takes time off work and is very caring. During the inspection the lead GP told us they very rarely take annual leave as patient care was prioritised. Plans were in place should they choose to take annual leave.

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:	

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)	96.9%	89.9%	92.9%	No statistical variation

Any additional evidence or comments

The practice were above local and national indicators for patient experience and satisfaction.

	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.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence:	

Carers	Narrative
Percentage and number of carers identified.	The practice identified 29 actively registered carers from a total population of 2,389 (1.2%).
How the practice supported carers (including young carers).	The practice were hoping to have a carers champion and patients advocate to support patients. Information for support groups was available at the practice.
How the practice supported recently bereaved patients.	The practice told us they would send a bereavement card and speak to the bereaved patient to offer condolences and signpost to support services. In addition, managers explained staff were also offered counselling and wellbeing support.

Privacy and dignity

The practice 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
Explanation of any answers and additional evidence:	

Responsive

Rating: Outstanding

When we inspected the practice in August 2019, we rated the practice as good for providing responsive services. At the inspection in October 2021 we found the provider was providing an outstanding responsive service as they had:

- Designed an annual plan to achieve patient outcomes and performance targets for disease management, such as childhood vaccinations and cervical screening. The plan detailed how many appointments and staff were needed per week and year to meet the performance targets. This included staff annual leave and sickness. This enabled the practice to effectively plan the appropriate appointments for patients. The practice aimed to offer 75 appointments per week per 1000 patients. In addition, the practice also had capacity for emergency and same day face to face appointments.
- The practice scored significantly above both local and national indicators for access to the service. Patient access to the service had not been compromised during a challenging pandemic, and with the practice patient list (increased by approximately 120 patients within a year) continually increasing the practice proactively responded to patient's needs. Numerous compliments and thank you cards from patients commended all staff for being helpful, friendly, sensitive and reassuring and for receiving an excellent service.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
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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 had designed an annual plan to achieve patient outcomes and performance targets for disease management, such as childhood vaccinations and cervical screening. The plan detailed how many appointments and staff were needed per week and year to meet the performance targets. This included staff annual leave and sickness. This enabled the practice to effectively plan the appropriate appointments for patients. The practice aimed to offer 75 appointments per week per 1000 patients. In addition, the practice also had capacity for emergency and same day face to face appointments. The practice had seen an increase of 120 patients registered with the practice within the last year, including an increase in babies and demand for immunisations. As a result, more appointments were made available to meet the needs of patient demand. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.00am – 6.00pm
Tuesday	7.30am – 6.00pm
Wednesday	8.00am - 6.00pm
Thursday	8.00am – 6.00pm
Friday	8.00am – 6.00pm
Appointments available:	<p>Morning and afternoon appointments were available daily Monday to Friday, with the exception on Wednesday afternoons where patients had access to a GP by telephone and appointments were available 4:00 pm – 5:00 pm. The practice offers extended hours on Tuesday morning.</p>

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> Patients had a named GP who supported them in whatever setting they lived. The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.

- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was open until 6.00pm Monday to Friday. Pre-bookable appointments were also available to all patients at additional locations within the area as the practice was a member of a GP federation. Daily appointments were available from 10.00am to 10.00pm at the Same Day Health Centre.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

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 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
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Patients were able to make appointments in a way which met their needs.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
There were systems in place to support patients who face communication barriers to access treatment.	Y
Patients with urgent needs had their care prioritised.	Y
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Patients could access home visits. The receptionist would take the details from the patient requesting a home visit and record in the patient record. The GP would call the patient to review and assess the urgency of the request. • The practice offered a combination of face-to-face appointments, telephone consultations and photo/video consultations, which patients could book online or by telephone. Where a patient presented clinically unwell, the practice first completed a telephone triage (except for lumps and abdominal pain, patients were booked in/prioritised immediately) and consultation to determine 	

their clinical priority. If necessary, a face-to-face appointment could then be arranged at a suitable and convenient time.

- The practice employed a range of clinical staff roles, including GPs, advanced nurse practitioners, dermatology specialist nurse, nurses, health care assistants and pharmacists. The practice were part of the north primary care network and had access to a clinical pharmacist, a pharmacy technician, four care coordinators, a podiatrist and a dietician.

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)	98.8%	N/A	67.6%	Significant Variation (positive)
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)	94.3%	64.8%	70.6%	Variation (positive)
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)	85.5%	63.1%	67.0%	Tending towards variation (positive)
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)	92.8%	79.7%	81.7%	No statistical variation

Any additional evidence or comments

The practice scored significantly above both local and national indicators for access to the service. Patient access to the service had not been compromised during a challenging pandemic and merits recognition of achievement. Patients were able to access care and treatment in a timely way to meet their needs.

Source	Feedback
Google Reviews	One review received in the last six months citing staff were professional, approachable and helpful.
NHS Friends and Family	The practice had received three surveys. All were positive about the choice of appointments and staff were friendly and informative.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care, however documentation required review.

Complaints	
Number of complaints received in the last year.	2
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	NA
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.	P
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection in August 2019, we found the practice had not received any complaints.</p> <p>At the inspection in October 2021, we found there had been no formal patient complaints documented.</p> <ul style="list-style-type: none"> Information on how to make a complaint was available in the practice leaflet and on the practice website, advising patients to contact the practice manager. The practice manager confirmed they had not received any formal complaints during the inspection. They told us they receive verbal niggles which they document and address. We reviewed minutes of a team meeting where two verbal complaints were discussed and action and learning had been agreed for improvement, but these were not formally documented anywhere to monitor and assess for trends. The practice were aware this was an issue prior to the inspection and agreed to formalise complaints records/monitoring. After the inspection the practice confirmed they had a system in place and complaints would be discussed at team meetings. The practice had a compliments and complaints book, where verbal feedback from patients was recorded in the book. The practice had received numerous compliments and thank you cards from patients commending all staff for being helpful, friendly, sensitive and reassuring and for receiving an excellent service. Feedback was shared at the practice team meeting. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient bereavement (verbal complaint)	The practice had not been notified by secondary care of the patient's death. Practice sent a bereavement card to the family.
Patient did not receive a call back from a GP (verbal complaint)	New patient contact details were not clear in their records. Staff to check all patients contact details were up to date.

Well-led

Rating: Good

When we inspected the practice in August 2019, we rated the practice requires improvement for providing well led services because leaders were not always visible at the practice, appraisals were inconsistent and not completed by an appropriate peer, the management and monitoring of risks lacked oversight, the practice did not have a culture which drove high quality sustainable care and the CQC were not notified in a timely manner of changes to the service.

At the inspection in October 2021 we found the provider had taken all the necessary actions to address the previous shortfalls and were now compliant.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels to deliver high quality sustainable care.

	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: At the last inspection in August 2019 we found: <ul style="list-style-type: none">Staff reported that they felt supported by the GPs through this challenging time at the practice and that they felt part of a team. However, they felt they sometimes lacked leadership. At the inspection in October 2021 we found: <ul style="list-style-type: none">Staff told us they felt more supported and management were approachable, and they worked well together as a team. The practice had also completed a staff survey, this showed staff were happy or satisfied.The practice had been through a challenging period with the long-term clinical absence of the GP since the last inspection and up until a new provider registration in May 2021. They had inherited the previous inspection rating, governance systems, financial issues and staff were reducing their hours due to progression towards retirement. The practice had also seen an increase of 120 patients registered with the practice within the last year, including an increase in babies and demand for immunisations. As a result, more appointments were made available to meet the needs of patient demand. The practice had focused on access and patient care, they were open, honest and aware of the challenges and were keen and proactive to improve. They had made changes, such as developing a practice website, implementing an annual plan to meet QOF performance targets, developing a business plan, conducting a staff survey, implementing new clinical policies, arranging regular meetings and appraisals. In addition, they had implemented an action plan for improvement to improve systems and monitoring oversight, such as significant events, complaints, audits, staff training and medicines management.A succession plan was in place and the GP had support from a long-term locum and a neighboring practice to allow for continuity, recruitment plans were in place for a GP, nurse and receptionist and plans were in place for when the practice manager retired.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had a mission statement on their website, which said 'We aim to provide effective and efficient primary care services to our patients, recognising and responding to people's needs in a friendly and approachable way and to promote a healthy, happy and rewarding environment for all the healthcare team'. This was shared with staff for their contribution. Staff said they were Involved in discussions leading up to the strategic planning. 	

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.	P
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.	P
Explanation of any answers and additional evidence: <p>At the last inspection in August 2019 we found:</p> <ul style="list-style-type: none"> There were gaps in management and support arrangements for staff, such as appraisal, and supervision. Some appraisals had taken place, the practice manager and one member of the reception team were scheduled to have an appraisal within the next week. However clinical staff members had not received an appraisal of their performance in their role from an appropriately skilled and experienced peer. The practice did not notify the Commission of the disruption to the running of the practice which was a notifiable event. <p>At the inspection in October 2021 we found:</p>	

- Staff confirmed they received regular supervisions, clinical peer support and annual appraisals. In addition, nurses were allocated time each day to discuss queries, guidance and learning with the lead GP.
- The practice told us they were familiar with notifications they must submit to the CQC regarding changes, events and incidents.

In addition, we also found:

- Although the practice had processes in place to learn from significant events and complaints, we identified not all significant events or complaints were formally documented. The practice were aware prior to the inspection of the shortfalls in the oversight of documenting and monitoring and had an action plan in place to address these areas.
- Six (out of eight) members of staff had not completed equality and diversity training. The practice were aware of this and confirmed the training was scheduled for November 2021.
- Staff told us managers and senior clinicians were approachable, and staff felt comfortable in raising any concerns to them.
- The practice had completed a staff survey in October 2021. 90% of staff said they had a good work life balance, 10% said they were satisfied.

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

Source	Feedback
Staff	Staff spoke very positively about working at the practice. They all said they worked well as a team to ensure patients receive the best possible care. They said the team were kind and considerate. They also said they maintained a high level of care during the covid pandemic despite the challenges.

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"> • Governance systems were reviewed during staff's annual appraisals and at team meetings. • Staff were clear about their role and how to access support. 	

Managing risks, issues and performance

There 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.	P
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
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection in August 2019 we found:</p> <ul style="list-style-type: none"> • The last fire risk assessment was completed in 2011. • Clinical audit activity was low, we saw evidence of a one cycle audit and a two-cycle audit. Audit activity was not scheduled in advance. • The practice had a system in place to monitor staff training. All staff were up to date with training except for one staff member who was due to complete safeguarding training as a priority. • There was a lack of oversight of significant events as actions were not documented in two of the significant events we viewed. • Staff were not aware of the major incident plan and had not received any training. <p>At the inspection in October 2021 we found:</p> <ul style="list-style-type: none"> • There was a fire risk assessment in place. • We saw evidence of three one cycle audits. As a result of the clinical searches, the practice confirmed they would engage in more detailed audits about creatinine clearance calculation (this is a calculation done using the kidney blood test and patient weight and age), asthma inhalers and blood tests for certain drug combinations. The audits were included in the practices action plan (presented at the site visit), with a plan to re-audit. • A major incident plan was in place and staff had received training in preparation of major incidents. • As part of an eight-practice primary care network there was constant benchmarking. Prescribing was scrutinised regularly with regular involvement from the pharmacist. • Regular staff meetings were held within each staff group to discuss any risks, issues or barriers to performance. • Although the practice had processes in place to manage and mitigate risks, we identified some risks during our inspection, such as effective management of medicines, that had not been identified or mitigated by the practice. The practice were aware prior to the inspection of shortfalls in the oversight of monitoring significant events, complaints and gaps in training and had an action plan in place to address these areas. The action plan also included medicines management. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Throughout the pandemic, the practice continued to provide appointments to patients, through a combination of face-to-face, online and telephone consultations. Where a face-to-face appointment was most appropriate for the patient's condition or individual needs, the practice continued to offer these services daily. Reserved appointment slots were allocated for children to review prior to the end of the working day. There was a low backlog of activity, asthma reviews were being completed by telephone appointments and minor surgery and joint injections had recommenced. 	

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
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection in August 2019 we found:</p> <ul style="list-style-type: none"> The practice had not formally notified the CQC of changes to their service in a timely manner. The CQC received the notification the day after the inspection. <p>At the inspection in October 2021 we found:</p> <ul style="list-style-type: none"> The practice told us they were familiar with notifications they have to submit to the CQC regarding changes, events and incidents. 	

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:	

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.	P
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 paused patient participation group (PPG) meetings during the pandemic and were in the process of resurrecting the group and encouraging new members to join to represent the different population groups. The PPG is promoted on the practice website and at the practice. 	

Continuous improvement and innovation

There was some evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	P
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<p>At the last inspection in August 2019 we found:</p> <ul style="list-style-type: none"> There was a lack of management oversight of significant events as actions were not documented in two of the significant events we viewed. 	

At the inspection in October 2021 we found:

- Staff were supported and encouraged to report issues and concerns to managers, and any learnings were disseminated to staff through team meetings. The practice were aware prior to the inspection of shortfalls in the oversight of monitoring significant events and an action plan was in place to improve oversight.
- The practice were committed to improving services for patients. They were aware of challenges and shortfalls and had a programme of audit in place to improve quality of care.
- Nurses were allocated time each day to discuss queries, guidance and learning with the lead GP.

Examples of continuous learning and improvement

- The practice had designed an annual plan to achieve patient outcomes and performance targets for disease management, such as childhood vaccinations and cervical screening. The plan detailed how many appointments and staff were needed per week and year to meet the performance targets. This included staff annual leave and sickness. This enabled the practice to effectively plan the appropriate appointments for patients. The practice aimed to offer 75 appointments per week per 1000 patients. In addition, the practice also had capacity for emergency and same day face to face appointments.

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.
- **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.
-
- ‰ = per thousand.