

Care Quality Commission

Inspection Evidence Table

Rolle Medical Partnership (1-584888930)

Inspection date: 17 August 2022

Date of data download: 11 August 2022

Overall rating: Outstanding

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.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: The practice training matrix showed all staff had received training. Staff were trained and knowledgeable about how to identify and manage safeguarding concerns. We were provided with an example of a complex safeguarding concern which was identified by reception staff, reported and action taken by senior staff to keep the patient safe. Disclosure and Barring Service (DBS) checks were completed for all new staff prior to employment commencing. The practice had a written protocol regarding employment procedures. This provided guidance to follow should a prospective employee make a disclosure or their DBS referenced information that could affect their employment. In these situations the practice managers and senior partners would review the information and make a decision whether employment would be offered.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed the personnel records for five members of staff who had been recruited within the last two years. The practice carried out thorough pre-employment checks for each member of staff. This included completion of an application form, curriculum vitae, and interview for which written records were maintained, two references and proof of identity.</p> <p>The practice provided training opportunities for trainee GPs through the local acute NHS trust. The practice did not maintain recruitment records for the trainee GPs. The NHS trust was the host employer for all trainee placements and the practice had a service line agreement (SLA) with the trust. The NHS trust had the responsibility within the SLA to ensure all pre-employment checks as per the NHS check standards including DBS check, occupational health and contractual arrangements were in place prior to allocating the trainee GPs to placement.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 21 July 2022	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 31 May 2021 (main) 24 May 2021 (Treetops surgery) Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Three out of 19 actions identified from the fire risk assessment were completed. Of those remaining, two were due to be completed in August 2022. We interviewed key staff who confirmed these were actioned and now resolved. The remaining actions were due to be completed after the inspection.</p> <p>We observed approximately 20 single wrapped needles used for injection that were past their use by date in one of the clinical rooms. We brought this to the attention of the deputy practice manager who immediately removed them.</p>	

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.	Yes
Infection prevention and control audits were carried out.	Yes

Date of last infection prevention and control audit: June 2022	
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.	Yes
Explanation of any answers and additional evidence:	
<p>The practice demonstrated appropriate Infection Prevention and Control (IPC) systems were in place:</p> <ul style="list-style-type: none"> • The practice had a legionella risk assessment that was rated, highlighting priority and dates of completed actions. For example, records demonstrated monthly checks were made of all water outlets in the building. We saw an invoice for paid contractor work to reduce legionella risk at the branch, Treetops Surgery in August 2021. • Staff training records demonstrated they had completed IPC training in the last 12 months. • Staff had access to detailed infection prevention and control policy and procedures which were stored on the intranet. • All clinical rooms had supplies of personal protective equipment and hand washing facilities including liquid soap, hand gel, paper towels and elbow operated taps. Waste was stored in pedal bins until removed from the building for storage waiting collection. The waste storage area was external to the building in a locked area. • Sharps bins were available in all areas, were signed, dated and not overfilled. • Clinicians were responsible for cleaning equipment after they used it and between each patient and the environment prompted control of the risk of infection • The practice had replaced a number of carpets within the clinical area to ensure appropriate cleaning could be carried out. • The practice manager and deputy practice manager carried out a 'walk through' of the environment which had last taken place in June 2022. Their observations had been included on an action plan which was updated and signed to show completion of actions. <p>However,</p> <ul style="list-style-type: none"> • On the day of inspection the consulting and waiting areas were free of clutter, visibly clean and tidy. However, there was one ceiling which had been damaged by a water leak and the paint was peeling. This had not been identified on the environmental risk assessment and repair had not been planned. The action plan had not identified who was responsible to ensure the action was completed and by what date. • A hand hygiene audit had been developed but was yet to be completed. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes

Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice demonstrated there were adequate systems to assess, monitor and manage risks to patient safety:</p> <ul style="list-style-type: none"> • The practice used experiential learning using simulated examples for practicing response in the event of a medical emergency, for example a child having an epileptic seizure or a child having a severe asthma attack. Learning was shared across the team. • Training records demonstrated staff were up to date with emergency training, including identification of a deteriorating patient, anaphylaxis and resuscitation. • We reviewed five personnel files for staff recruited in the last two years. Each had an induction checklist which included organisational induction and an induction training pertinent to their role. An induction was provided for temporary staff such as locum GPs and agency nursing staff. • The practice had obtained posters and leaflets for staff relating to updated sepsis guidance. This had been discussed at team meetings. We saw the posters displayed prominently for reception staff and within clinical rooms. • The practice had links with the mental health children's services team which were part of the PCN. This team worked across sectors including education and facilitated information sharing regarding children and young people experiencing mental health issues. • The practice managed the risk to patients of deteriorating health. Through discussion with clinicians it was apparent they knew their patients well and made decisions based on information provided of the appropriate method of consultation. For example, one clinician carried out a home visit to a patient after a consultation by telephone. They knew the patient well and made the decision that a home visit was required to ensure the patient was not experiencing a deterioration in their long-term condition. 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice demonstrated there was appropriate information to deliver safe care and treatment:</p> <ul style="list-style-type: none"> • The practice used standardised templates, which generated a red flag task to secretaries for any urgent referrals made. An automatic text message was sent to each patient awaiting an urgent referral appointment advising them to notify the practice should they not be called by the secondary healthcare service. • In interviews, staff verified that searches were carried out every week to promote patient safety and provided assurance for the practice that urgent referrals were follow up. The practice implemented this system following a learning event. Regular audits provided assurance of effectiveness of this system. 	

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	0.78	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)	6.8%	9.1%	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)	5.05	5.71	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	161.2‰	140.4‰	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)	0.91	0.73	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	7.1‰	7.5‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	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.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	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.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice demonstrated it had systems for the appropriate and safe use of medicines:</p> <ul style="list-style-type: none"> The staff had access to emergency equipment and medicines which was located centrally within the clinical area. The emergency medicines were stored in a grab bag which was secured with a tamper evident seal. The seal had a serial number clearly identified. However, staff did not record the serial number so could not evidence when the seal had been renewed. This was addressed during the inspection. 	

- Daily and weekly checks were made of the emergency equipment which were recorded. The medicines were checked when used and the bag opened, or when a medicine contained within the bag was nearing expiry and replaced. The date of the closest expiry date was recorded on the rear of the security tag for ease of use.
- Additional emergency medicines were stored in a central cupboard which was locked and the key held in a metal cupboard secured by a key pad. Clinical staff had access to the key pad. Clinicians recorded any medicines they had removed, the date and for which patient. This provided an audit trail of medicines within the practice and enabled ease when restocking and ordering medicines.
- Prescription paper was stored in printers which were locked to prevent unauthorised removal. Spare prescription paper was stored in each clinical room in a locked drawer. The prescription paper was identifiable to each room so could not be used outside of that area. This helped provide an audit trail of when and how prescriptions were used.
- Patient Group Directions (PGDs) were made available to staff in paper form. (PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines). All PGDs had been signed by each nurse and authorised by either a GP or nurse prescriber. However, we identified that three out of the five PGDs we reviewed had been signed by nursing staff after the nurse prescriber or GP had signed to say they had authorised them. This meant a nominated person had not authorised the nurse to use the PGD.
- Patient Specific Directions (PSD) were held electronically on the patients medical records. (A (PSD) is an instruction to administer a medicine to a list of individually named patients where each patient on the list has been individually assessed by that prescriber.) The PSDs identified the medicine, dosage and frequency. When nearing the expiry date of the PSD the staff alerted the GP or nurse prescriber to review the patient record and PSD prior to it being updated.
- Fridge temperatures were recorded daily and recorded online. A dongle inside the fridge recorded temperatures electronically which were reviewed weekly.
- Medicines were stored in a locked cupboard in a utility room. This room was left unlocked and the door open at times during the inspection. The key for the medicines cupboard was out of sight but not secured. This meant unauthorised persons could potentially access this key.

In clinical searches, we looked at the management of patient safety for those on high risk medicines. Initial findings indicated there could be gaps but the practice provided further assurance immediately after this was undertaken:

- 19 patients were prescribed Azathioprine (Disease modifying anti-rheumatic medicine). We found three patients had not had the required monitoring through blood testing every three months. However, immediately after the inspection the practice provided additional information of dates demonstrating all of the patients had the required monitoring at the practice or were under hospital care.
- 89 patients were prescribed spironolactone or eplerenone (potassium sparing diuretics commonly used to treat high blood pressure). We found 10 patients were overdue the required monitoring every six months. The practice provided further information, demonstrating: several attempts had been made to recall patients, which had been successful and monitoring undertaken at the practice or the patient was under secondary care and was being monitored. Three patients did not engage easily with the recall process and had resulted in delayed monitoring. The practice told us they would review the recall letter to patients stating that without the requisite monitoring some of their medications might not be issued until this was done.
- 1543 patients were prescribed an ACE inhibitor or Angiotensin II receptor blocker. We found 88 patients were overdue monitoring required every 18 months (during the Covid-19 pandemic). Immediately following the inspection the practice carried out a search and reviewed secondary

Medicines management**Y/N/Partial**

care records. This information showed patients had been recalled several times and appointments booked, or were under secondary or community nursing care and had had the appropriate monitoring of kidney function. Four patients were no longer prescribed this medicine.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	19
Number of events that required action:	19
Explanation of any answers and additional evidence:	
<p>The practice had a good track record on safety, demonstrated by:</p> <ul style="list-style-type: none"> • Staff we spoke with were aware of the significant event process and how to report concerns. • Information regarding the reported significant events was stored on the practice intranet and available for staff to review and take learning from. Outcomes from significant events were also discussed with individual team members and at team meetings. 	

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

Event	Specific action taken
A wrongly labelled specimen	Discussion with staff teams regarding checking the patient details prior to sending and with the patient if present. The duty of candor process was followed which included an explanation and apology to the patient. However, it was not recorded that the explanation and apology had been provided to both patients involved. The practice manager provided assurances this would be reviewed and evidenced.
The care and treatment provided to a patient following minor surgery in a secondary care location	Additional lone working information had been provided to all staff together with training on responding to haemorrhaging and referring patients to out of hour services.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	

The practice manager had oversight of all safety alert information and disseminated this across the team for action as applicable. In interviews and responses to a CQC survey, staff verified safety alerts were shared, actioned and changes made where appropriate.

In clinical searches we found nine patients were prescribed citalopram. An older legacy MHRA alert had highlighted associated risks when taking this medicine which could affect the heart. Five of the nine patients on citalopram were overdue review, which the practice was aware of and actioning. Immediately following the inspection, the practice provided confirmation of the dates that all patients on this medicine had booked appointments for monitoring.

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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence:	
The practice demonstrated it had effective systems ensuring the needs, care and treatment of patients was a priority:	
<ul style="list-style-type: none">• Regular clinical meetings were held, including educational meetings where current guidelines were discussed.• GP registrars undertook regular searches and presented findings against current guidelines providing updates to all clinicians. This highlighted when action was required.• An audit of patients diagnosed with coeliac disease (Autoimmune inflammatory disorder provoked by gluten diet) analysed completed patient reviews against NICE guidelines. People with coeliac disease are at risk of vitamin deficiencies, bone disease and cancer due to this disorder. Awareness was raised across the clinical team and an annual review flow chart developed to prompt appropriate monitoring and patient engagement took place.	

Effective care for the practice population

Findings

Exmouth is a popular area for retirement and older people living in the area. 29.2% of the practice population is older patients which is much higher than the national average. The practice had arranged services accordingly:

- A GP partner was lead for overseeing support to older frail patients across the primary care network, including those living in 17 adult social care homes. The frailty team worked collaboratively undertaking complex patient reviews, structured medication reviews, and care home education. Virtual or face to face multi disciplinary ward rounds for each care home were being trialled with their nominated GP every six weeks.
- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice 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.
- The practice had appointed a GP with special interest in womens healthcare, specifically with expertise in menopause care.

Management of people with long term conditions

Findings

During the COVID-19 pandemic the practice had followed national guidelines in regard to monitoring patients, which in some cases extended the timescales required to complete this. We carried out clinical searches to establish how effective the practice was at managing people with long term conditions, including ongoing medicine and blood test monitoring. We found:

- 14 patients with a potential missed diagnosis of diabetes. We sampled five patient records and asked for further information from the practice, which we received. All of the patients had appointments booked with the diabetic nurse specialist demonstrating a plan for follow up of results. One patient record had been updated and coded with a diagnosis of diabetes.
- Patients with long-term conditions were offered a structured annual (or extended due to the pandemic) review to check their health and medicines needs were being met. The practice had oversight of overdue monitoring and demonstrated it had an action plan to address any gaps caused during the pandemic.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. For example, nurses held diploma level qualifications for management of patients with respiratory disorders and diabetes.
- 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,	88	89	98.9%	Met 95% WHO based target

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)				
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)	89	92	96.7%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	89	92	96.7%	Met 95% WHO based target
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)	89	92	96.7%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	122	123	99.2%	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 offered appointments out of work times and were proactive in educating parents about the importance of childhood immunisations. Nursing staff carried out home visits for large families who found it difficult to attend the practice for immunisation. Some families chose not to have their children vaccinated and the practice contacted health visitors to make them aware and discussed this issue at safeguarding meetings.

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: 31/03/2022) (UK Health and Security Agency)	80.1%	N/A	80% Target	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	75.4%	66.5%	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)	76.3%	71.4%	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)	54.7%	56.6%	55.4%	No statistical variation

Any additional evidence or comments

During the Covid-19 pandemic, the practice continued to perform cervical smears for eligible women. 421 cervical smears were performed in 2020. Data showed the practice was continuing to perform highly and had met the national target of 80%.

The practice had a cervical screening policy, which outlined delivery of the service, standards, authorized smear takers, safety netting and audit methods as assurance of effectiveness. This included:

- Each nurse who performed cervical screening maintained a record of the screenings undertaken and the results obtained. They followed up any results which were delayed and contact patients when necessary.
- Staff we spoke with told us how they discussed inadequate results with colleagues and provided in house training and support to nurses new to the cervical screening process.
- Staff took opportunities to discuss the process with patients who had attended for other reasons to encourage them to attend for screening. One nurse we spoke with explained how they also telephoned patients known to be overdue their screening, to discuss the reasons for this and explained the process to help the patient to make an informed decision and reassure them.
- The staff endeavoured to provide short notice appointments or extended appointments to support women to have cervical screening.
- Patients with additional needs were supported through the procedure. For example, a patient with a learning disability was able to bring their support worker with them. The support worker remained in the room but outside the curtain for privacy. A woman whose first language was not English was supported by an interpreter, who again remained in the room but outside of the privacy curtains.
- Information regarding the procedure and the importance of attending was available to patients on the social media site and on the website.

Monitoring care and treatment

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

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

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

Quinine prescribing audit - The audit looked at 44 patients who were prescribed quinine (medicine commonly used to treat nocturnal cramps), specifically to identify if any patients had this on repeat prescription. Guidelines indicated this medicine should be used short term and stopped if no benefits were seen for the patient. After the audit the number of patients receiving this medicine was reduced to 23 patients after consultation regarding the risks of quinine long term. However, a recent re-audit showed that those figures had increased again to 47 patients on a repeat prescription, which the practice was actioning at the time of the inspection. Many of the patients in this repeat audit had restarted the treatment after their condition worsened once they had stopped it.

Antibiotic prescribing - The audit reviewed antibiotic prescribing for patients diagnosed with diverticulitis. This aimed to provide assurance and established whether national guidelines for the treatment of diverticulitis, to follow a no antibiotic prescribing strategy wherever possible, was being followed. The first audit figures for the antibiotic prescribing for diverticulitis was 44%, however on re-audit this had reduced by 2% to 42%. At the time of the inspection, further audit was underway to complete a more indepth review of each patients records to understand the prescribing fully.

Any additional evidence or comments

Quality improvement activities during the pandemic included a focus on patient access. 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.

Since national guidance changed there has been a more flexible approach to patients interacting with their practice, with increased telephone and online consultations. The practice carried out an audit to improve the process of handling e-consultations (online) to ensure GPs reviewed any requests within 48 hours.

Audit of coding patient records – in 2020 the practice carried out an audit for assurance of the effectiveness of codes applied to patient records to facilitate accurate searches and ongoing monitoring of patients. The audit highlighted improvements could be made to the process to facilitate GP sampling, for assurance, of 20% of records for accuracy and completeness. This was due to be repeated.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence:	
Data showed the practice had carried out:	
<ul style="list-style-type: none"> • 212 NHS checks for patients aged 40 to 74 - The practice allocated ten appointments per week for the health checks. Regular reports were run from the electronic system to identify eligible patients and the administration team sent out letters to invite patients to attend. • Staff used the NHS health check process to promote a healthier lifestyle and prevent ill health. Following the health check, appointments were booked with appropriate clinicians if required, subject to the patients consent. • 2031 out of 2341 completed NHS checks for patients aged 75 plus. • Patients had access to a social prescriber shared across the primary care network. People were signposted to initiatives supporting them to improve their fitness and health, for example supported walks around the area. 	

Consent to care and treatment

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

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

In January 2022, the frailty team led by a GP at the practice initiated an audit to review admissions to hospital from care homes. A total of 33 admissions had taken place in a 12 month period. On review of those admissions it was felt that five were avoidable following a review of the patient clinical records by the frailty team and geriatrician. Of the five patients, three did not have an up to date treatment escalation plan (TEP). The team had an action plan underway to address these findings which included: educating clinicians to support all patients residing in care homes to have clear, well defined TEPs in place and a collaborative delivery with an external organisation to increase the knowledge and skills of care home staff in regard to anticipatory care.

At this inspection, we sampled five patient records and found the TEP had been reviewed.

Responsive

Rating: Not rated

Rolle Medical Partnership was rated outstanding for the provision of responsive services at our last inspection in 2016. In accordance with Care Quality Commission's methodology, the rating from our previous inspection for this key question has been carried forward to contribute to the overall rating for the practice.

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	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
Explanation of any answers and additional evidence: The practice sent us guidance regarding appointment access and a flow chart for staff to follow to determine the right support and appointments needed for patients. The patient information leaflet did not fully reflect the arrangements for new patients. However, we saw the practice website provided more detailed information about accessing services. We received feedback from 30 patients as part of this inspection. Half of the responses highlighted patient frustration in getting face to face appointments with a GP during the COVID-19 pandemic. Two included reference to being offered an appointment with another clinician such as a nurse practitioner. All patients were offered an appointment, the majority within a short timescale.	

Throughout the inspection, we looked at evidence including interview and observation of how the practice was managing access for patients. Patient representatives explained patients registered with the practice were accustomed to an exceptionally responsive service prior to the COVID-19 pandemic and some struggled with the changing service. The practice was aware patients were more frustrated with arrangements, which were changed in line with national guidelines and closely monitored this through audits.

Patient views were listened to and improvements were being made as services were returning to normal following the pandemic, these included:

- Making patients aware of a multidisciplinary team approach and signposting to the right type of appointment with appropriately skilled staff to meet the needs of each patients.
- The practice had recently introduced a digital advocate whose role was to support patients with accessing appointments by providing support to access E-Consultation, registrations, websites and the NHS Application.
- The practice manager described how vulnerable patients and carers were able to contact them directly. For example, one carer could access the practice manager through email for support when required.
- Care home managers and other external professionals were provided with a dedicated telephone line which they could raise queries and concerns.

During the inspection, we observed the reception team greeting patients who arrived in person at the practice and also responding to telephone calls. Our observations saw staff to be kind, caring, polite and respectful to patients. They provided information and support for patients with queries and efficiently booked the most appropriate appointment for the patient.

We were provided with examples of kind and caring staff who at times went over and beyond to support patients. For example:

- A patient had fallen following their appointment. Once checked by a clinician, a member of staff helped the patient home in a wheelchair, made them a cup of tea and settled them prior to returning to the practice.
- Another patient who was distressed was provided with an early appointment at the practice, was supported with staff to wait in a private area and provided with a cup of tea.
- Another patient who lived with dementia and was normally visited at home had arrived at the practice appearing confused and disorientated. Two members of staff had driven them home, settled them at home and made them a cup of tea before leaving.

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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence:	
<p>Leaders demonstrated continued compassionate, inclusive and effective leadership. Examples seen were:</p> <ul style="list-style-type: none"> • There were a number of refugees registered at the practice (Afghan and Ukrainian). When Afghan refugees arrived in September 2021, the practice set up an out reach clinic at a local hotel where they were residing, to build relationships and ensure they understood how to access services. A GP was the locality area lead and increasing their knowledge about paediatric refugee health via training. • The practice set up a special clinic in 2022, in response to a Public Health England (PHE) alert as refugees had arrived into the local area who had been exposed to measles and were un-vaccinated and at risk. The practice manager led and co-ordinated a collective response across Exmouth practices and arranged for vaccines to be pooled, ordered and distributed so that all practices could arrange a clinic at short notice in order to ensure all at risk patients were vaccinated. 	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence:	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence:	
<p>The practice carried out an annual staff survey every year and had a well-being strategy. The practice sent us a copy of the last survey in 2021, which was undertaken to monitor and improve resilience of staff during the COVID-19 pandemic. The practice survey highlighted:</p> <ul style="list-style-type: none"> • Work related stress had slightly increased for staff due to the COVID-19 pandemic when the NHS was under significant pressure. • Three people had reported that they saw a near miss however they did not report it. • An action plan was put in place to address the issues and improve staff well-being for the remainder of 2021/22. Social events, rewards and recognition and creation of lead roles aimed at valuing staff had been increased. <p>Staff we spoke with during the inspection felt supported and valued by the practice. Staff commented on the open door policy within the practice and how they were able to raise issues and concerns, felt listened to and were confident that any issues raised would be addressed. Staff consistently spoke of the team approach within the practice and how they all felt part of the team which supported each other.</p>	

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

Source	Feedback
Interviews with staff	All of the staff interviewed gave positive feedback about the leadership team at the practice. Staff told us they felt well supported and encouraged to develop their career by being able to access training to increase knowledge and skills.
CQC staff survey	All of the surveys received were positive, highlighting that the practice had processes and procedures in place that were regularly reviewed and promoted high quality care of patients.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:	
Responsibilities, roles and systems of accountability were demonstrated by:	
<ul style="list-style-type: none">All GP partners had a lead role and there were systems in place to support good governance and management. For example, the frailty lead GP had oversight of the team monitoring the most frail patients in the community. They were accessible to the staff at the practice and those in the community supporting patients. Regular meetings were held to review patient needs that included review and prioritisation of ongoing support needed.	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance. However, we found some areas needed to be reviewed to enhance arrangements in place.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence:	
<p>We saw several examples of effective arrangements for identifying, managing and mitigating risks:</p> <ul style="list-style-type: none"> • Training was monitored - systems facilitated identification of any gaps in mandatory or role specific training for staff, which had been actioned. • A number of meetings were regularly held weekly, monthly and bimonthly with different staff groups. Minutes showed staff received feedback about performance, for example being thanked for completion of annual patient reviews. • Reception staff spoke about times of high call volumes. They were able to monitor how many patients were waiting to access the service. There were arrangements in place for other staff within the practice to access telephone lines and respond to calls waiting. We were provided of examples of when this had happened with the outcome that the calls waiting reduced significantly and quickly. The reception team lead worked alongside the reception staff and monitored the call volumes. The reception manager was located in an office at the rear of the reception area and provided support when needed. • The reception desk had a panic alarm for staff to press if they required additional assistance. We were provided with examples of when this had occurred. One member of staff had used this when they had a patient who became unwell and clinicians had responded promptly. Other staff had access to call for assistance through their computer key board. Staff were informed of these systems during their induction. • All the staff at the practice were trained in Identification and Referral to Improve Safety (IRIS) training with refresher sessions. The IRIS worker attended safeguarding meetings to provide more support to patients who might not have been identified but who could benefit from support. A GP had recently been appointed clinical advisor to IRIS for Devon. The practice was one of the highest referrers to this service demonstrating appropriate identification of women in need of support from abusive relationships. <p>However, we found some areas needed to be reviewed to enhance arrangements in place:</p>	

- Regular infection prevention and control (IPC) audits had not recently included hand hygiene audit to ensure staff practice was effective and embedded.
- Checks of emergency equipment did not include an additional level of assurance of continuous no tamper safeguards for the emergency grab bag.
- Although signed and dated by the prescribing GP partner, patient group directions (PGDs) were not always authorised in the correct sequence, which was, after signatures were obtained for clinical staff undertaking vaccination and immunisation of patients.
- Some non patient areas, where clinical equipment and medicines were stored, could easily be accessed by patients during the day.

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

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

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence: Appropriate and accurate information was held:	

- Complaints were monitored and reviewed to identify themes and trends. Action was taken to raise complaints with staff members mentioned in the complaint, to provide learning and aid the investigation.
- We reviewed four complaints received by the practice in the past year. Records showed the complaints were discussed, investigated and the patient responded to on receipt of the complaint and following the investigation with an outcome. Duty of candour legislation was followed when appropriate. The practice manager was able to demonstrate that following receipt of a complaint they rang the complainant to discuss their concerns and advise on the process. This telephone call was followed up in writing to the complainant.

Governance and oversight of remote services

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence:	
<p>Staff verified they were encouraged to make suggestions for improvement, which led to improved service delivery for patients, for example:</p> <ul style="list-style-type: none"> The nursing team reviewed and implemented a new protocol for patients with a suspected urine infection. Minutes documented this had reduced the number of urine samples needing to be checked and workload. <p>Patients gave ongoing feedback through the patient participation meetings, 'Friends and Family Test' surveys and via social media:</p> <ul style="list-style-type: none"> The practice collated and shared 'Friends and Family Test' feedback for January to March 2022, which was positive. Sixteen patients who gave feedback indicated their overall experience was either very good or good at the practice. No negative comments were received. The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022) was significantly above the national average (practice 86%, national 53%). The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022) was tending towards a positive trend above (practice 72%, national 55%). 	

Feedback from Patient Participation Group.

Feedback
<p>We received feedback from the chair person of the Patient Participation Group (PPG). They told us there were 10 active members of the PPG who prior to the COVID-19 pandemic had normally met approximately five times a year. Face to face meetings had been paused during the pandemic and were replaced with online meetings. Practice staff were said to attend the meetings providing helpful briefings and reports with discussion and patients felt their comments were listened to and acted upon.</p>

PPG members were proactive in engaging with the wider community in some activities and this was encouraged by the practice. For example:

- Running well-being sessions every Wednesday lunchtime.
- Organising a book-stall and annual raffle, which raised funds and interest.
- Organising an annual raffle to provide additional funding. The PPG fundraising activities had recently enabled the purchase of a cholesterol testing machine.

Any additional evidence

The practice manager told us they had offered the use of land around the practice and had suggested a gardening group could be set up to support inclusion objectives for the community. This was still under discussion at the time of the inspection.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	
<p>At the last inspection in 2016, we found there was strong focus on continuous learning and improvement at all levels within the practice.</p> <p>At this inspection, we found:</p> <ul style="list-style-type: none"> • The practice team continued to be forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, learning from a significant incident had driven change. The practice had led the development of a primary care network single point of access for children and young people to access mental health and emotional well-being support. • This training, teaching and research practice had three GP trainers supporting three GP registrars. Reports from the accreditation body demonstrated a continued track record of successful support given to trainees and a high level of education. • The practice continued to have a student nurse mentor and had the capacity to provide placements for student nurses during their training. • Practice GPs had lead roles outside of the practice in the locality which helped them to deliver the most up to date care to their patients. These included lead roles in frailty, rheumatology, dermatology, cancer and health education which provided access for patients to near to home expertise rather than attend local hospitals for their diagnosis. • The practice actively participated in research to enable positive patient outcomes. This included involvement in research studies on numerous conditions. 	

We saw improvements made, for example:

- Clinicians had identified there were increasing numbers of urine samples being provided by patients without a clear process or system to follow. National guidance had been researched and reviewed and a new system developed with appropriate documentation for staff to complete and follow. This had resulted in a reduced number of urine samples processed and clear reasons for the provision of the sample and actions to take available to staff.
- The whole team worked together to support other roles. For example, to enable the reception/administration team to have a whole team meeting, clinicians had answered the telephones to patients. There had been learning taken from this experience of the issues the reception staff experienced and it was planned to develop this further as a learning experience for all staff.
- The practice had established links with a school which supports young people who are deaf when they had moved into the area and supported the registration of people resident at the school. A learning session run by the school team increased awareness for the practice team of the needs of people living with hearing impairment.

Examples of continuous learning and improvement

The practice had trialled and recently purchased a machine which was located in the waiting area. The machine read the patient BP, weight, height BMI and pulse. This was then provided to staff either from a print out or imported into the electronic patient record system.

The practice had identified that during and post Covid-19 there had been a lack of support in the community for patient groups. For example new mothers. The practice manager was in the process of looking into the provision of a Mum and baby/toddler group to enable new mums to meet together and be provided with support and guidance such as regarding baby immunisations, health promotion and provide a toy library. This was in the early stages of planning.

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.