

Inspection Evidence Table

Wallington Family Practice

(1-562775882)

Inspection Date:

Date of data download: 03/08/2023

Overall rating:

Requires improvement

At the last inspection in January 2017, we rated the practice as Good.

Following this inspection we have rated the practice as requires improvement because of issues that need to be addressed in safety, effectiveness, responsiveness and being well-led.

Safe

Rating: Requires improvement

At the last inspection in January 2017, we rated the practice as good for safety.

At this inspection we have rated safe as requires improvement because:

- Systems and processes to keep people safe and safeguarded from abuse were not consistently implemented.
- There were gaps in systems to assess, monitor and manage risks to patient safety.
- Systems for the appropriate and safe use of medicines were not consistently effective.
- The practice did not have a consistent and effective system to learn and make improvements when things went wrong.

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse, but they were not consistently implemented.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial ¹
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.	N ²
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> <ol style="list-style-type: none"> The practice safeguarding policies had definitions of female genital mutilation (FGM), but did not have any information for staff on how to identify it or actions to take if identified. Staff had received training on FGM and we were given an example of appropriate action when staff had identified a patient at risk of female genital mutilation. Shortly after the inspection the practice created an FGM policy with clear actions for staff. The DBS check on file for one clinical member of staff who was recruited in 2020 had been carried out in 2015 by a previous employer. There was no risk assessment on file that explained the decision not to carry out a DBS check before the staff member began in post. There was no Disclosure and Barring Service (DBS) check on file for one of the GP partners. This was supplied shortly after the inspection visit. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N ¹
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	N ²
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> We looked at the recruitment records of three members of staff. <ul style="list-style-type: none"> For one clinical staff member, the only references had been provided by colleagues (including for previous employment concerned with the provision of services relating to health or social care). There was no risk assessment on file of the decision to accept these as satisfactory evidence of conduct rather than seeking evidence from the employers. The employment history of the same staff member showed a gap in employment, and there was no written explanation for this on file. None of the three staff files we looked at had evidence of immunity to all of the illnesses recommended by current UK Health and Security Agency (UKHSA) guidance. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Partial ¹
Date of last assessment: Health and safety & Disability access risk assessments	15/08/2023
There was a fire procedure.	Y
Date of fire risk assessment:	12/09/2023
Actions from fire risk assessment were identified and completed.	Partial ²
<p>Explanation of any answers and additional evidence:</p> <p>1. The practice was based in a large health centre, which also contained another GP practice and a number of other health services.</p> <p>Health and safety risk assessments had been carried out on 15/08/2023. The practice had no previous comprehensive assessment of health and safety carried out or accessed by the practice, although some assessments of particular issues had been carried out previously. Actions recommended by the recent assessments had been taken.</p> <p>2. The most recent fire risk assessment was carried out on 12/09/2023. The practice had an action plan for the recommendations from this and had taken some of the actions,. Some of the actions needed co-ordinations with the building manager and other tenants of the building.</p> <p>A fire risk assessment was carried out in July 2021. We asked for an action plan from this risk assessment, but none was provided, and we noted that there were some recommendations that were repeated.</p> <p>Fire marshals had been appointed, but at the time of the inspection they had not all completed training. Shortly after the inspection we were sent evidence of training completed by the two fire marshals that had not completed it previously.</p> <p>We looked at the fire action records from 06/08/20 to 14/09/2023. There was no evidence of fire evacuation drill in 2022.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met, but processes to prevent and control the spread of infection were not consistently effective.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y

Date of last infection prevention and control audit:	18 July 2023
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice carried out internal checks of infection prevention and control. The most recent was in May 2023. These checks were not carried out against a checklist or documented list of aspects to be checked so it was not possible to know what had been assessed. The practice planned to introduce a more structured review template in future.</p> <p>The practice received an external audit of infection prevention and control in August 2022. There was no action plan available related to the recommendations from this audit. Another external audit of infection prevention and control was carried out in July 2023. We saw evidence that the practice had acted to improve infection prevention and control.</p> <p>An assessment of the risk of legionella bacteria was completed in August 2022. Eight actions were recommended. One of these was designated as high risk defect and was recommended to be completed within 0 – 3 months (replacement of corroded bolts in contact with water supply) and 5 actions were designated as medium risk and recommended to be completed within 3 – 6 months.</p> <p>We asked for evidence of action to address the recommendations of the legionella risk assessment. The building manager was away at the time of the inspection visit and an action plan was not available. Shortly after the inspection we were sent an email from the building manager that stated that three recommendations had been acted upon. The email explained that replacement of the corroded bolts or replace the water tanks was still being looked at, but that this, and another 3 recommendations had been mitigated by sterilisation of the water system. We were sent evidence that sterilisation had been carried out in September 2023. No specialist assessment was supplied as to the extent that sterilisation, which was not one of the recommendations of the report, addressed the risks identified such that the recommendation to replace the corroded bolts within 3 months could safely be delayed by more than 12 months.</p>	

Risks to patients

There were gaps in 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.	Partial
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y

Explanation of any answers and additional evidence:

Information about the emergency medicines held by the practice at the time of the inspection visit is in Medicines management (below).

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment, but care was not always fully documented in patient records.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Partial
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:	
In general, patient records reviewed were managed in a way that enabled staff to deliver safe care and treatment. However we found some records where patient results, clinical assessments or advice had not been adequately documented within the patient record.	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation, but they were not consistently effective.

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.99	0.78	0.91	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	8.2%	7.9%	7.8%	No statistical variation

antibacterial drugs (BNF 5.1 sub-set). (01/04/2022 to 31/03/2023) (NHSBSA)				
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 (01/10/2022 to 31/03/2023) (NHSBSA)	5.03	5.45	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	72.8‰	60.6‰	129.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.56	0.51	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	6.0‰	4.8‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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.	Partial ¹
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Partial ²
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.	Partial ³
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Partial ⁴
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
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.	Partial ⁵
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ol style="list-style-type: none"> The practice had recently introduced a documented system of clinical supervision. The provider explained that there had previously been supervision, but that was not always documented. We looked at two examples of a clinical supervision for a non-medical prescriber and could not see evidence that prescribing had been reviewed. The practice told us that the non-medical prescribers had a very small scope of prescribing. We looked at 5 examples of medicine reviews. In 4 of these we saw that medicines for only one of the patient's medical conditions had been reviewed. The coding of patients as having received a medicine review when not all medicines have been assessed means that these patients do not show as needing further assessment and therefore may not receive effective care. The clinical searches identified a total of 9 patients taking a medicine which may be used to treat rheumatoid arthritis and other inflammatory conditions. Of these we identified 2 patients who appeared to be overdue appropriate monitoring. We sampled both of these and found that 1 patient had no recent weight or blood pressure recorded. The clinical searches identified a total of 5 patients taking a medicine which may be used to help stabilise mood. Of these we identified 2 patients who appeared to be overdue appropriate monitoring. We sampled both of these and found that monitoring was incomplete. The provider told us that there were challenges with ensuring patients attended for monitoring and getting access to blood tests when completed by the hospital. The practice was taking steps to improve monitoring patients' health in relation to the use of medicines by establishing a practice-based phlebotomy service (as the local service for blood tests had become less convenient for patients and by recruiting a recall manager to manage communication with patients about monitoring. There was no formal documented system to monitor the prescribing of controlled drugs. The practice told us that these medicines were not added to repeat prescribing and use was monitored by GPs before prescriptions were issued. GPs each had a named list of patients, which the practice felt improved continuity and monitoring of care. At the time of the inspection the practice did not stock all of the emergency medicines recommended by guidance. There was a risk assessment to determine the medicines held, but this was incorrect (e.g. because it said that it would be dangerous to stock a medicine required to treat a complication of minor surgery. Shortly after the site visit the practice sent us a revised risk assessment and evidence that additional medicines had been obtained. 	

Track record on safety and lessons learned and improvements made

The practice did not have a consistent and effective system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
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.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	44
Number of events that required action:	42
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had a log of significant events. For some significant events there was no information as to whether actions had been completed and whether or how the learning had been shared. • We asked the practice for documents related to 3 significant events. Practice records suggested that there was not timely documented discussion of these, although the practice told us that there were informal discussions earlier than the documented meetings. • There was no documented system to check that actions agreed following significant events had been implemented. Actions agreed in meetings were not consistently recorded or consistently reviewed at the next meeting. • There was no documented system to review if there were themes in significant events or to confirm actions taken were effective. • The practice told us of a plan to have staff who take minutes receive extra training to improve the quality of record-keeping. • After the site visit inspection the practice told us about a new quality assurance process, which would include a formal documented review of significant event themes and actions. 	

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

Event	Specific action taken
Loss of internet to the practice impacting multiple systems	<p>The practice lost access to several key IT systems for more than an hour.</p> <p>The learning included the need for:</p> <ul style="list-style-type: none"> • staff to understand how to use a key system in business continuity mode • packs of paper forms for use in emergencies

	<ul style="list-style-type: none"> laptops to be turned on and updated more frequently. <p>We saw and heard from staff about actions taken but not all of the actions (e.g. a process to update the laptops more frequently) had been recorded in the practice business continuity plan.</p>
Death of a patient	<p>The death was subject to a coroner's investigation. There was no documented discussion of the events to look at whether there was any learning for the practice until after coroner's inquest (approximately a year after the patient's death).</p> <p>Minutes of the meeting note that the practice should have carried out analysis of events before the report was submitted to Coroner.</p> <p>Two actions were recorded in the minutes to address the learning identified. We asked the practice about these actions.</p> <ul style="list-style-type: none"> One action, to create a specific policy for inquests, had not been implemented. It was not clear why an alternative action – the update of a policy on actions to take after a patient death - was implemented instead, as this did not address the issues noted in the minutes. Staff told us that although the actions related to inquests were not documented they had been shared and were being implemented. The second action, a review of patients on particular medicines was in progress. We saw that the practice had created a protocol for the reviews and heard from staff as to how they were being completed, but there had not been any audit to confirm whether all of the expected reviews had been completed.
Patient letter uploaded to the records of another patient	<p>The practice reviewed the event and found that there had been a human error as the patients had similar details.</p> <p>Staff who managed incoming documents were reminded of the need for extra care to ensure identification of the correct patient.</p>

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>There was a system for recording and acting on safety alerts, but based on patient records we reviewed it was not consistently effective. We noted that for two separate safety alerts related to medicines, patients had not been identified and received advice about the risks until after the inspection was announced.</p> <p>The provider told us that it had looked at these and identified that although all patients had been reviewed at the time of the alert, there was not a consistent system to check that new patients who joined the practice received advice related to medicines or when hospital doctors prescribed medicines subject to alerts, and that this would be addressed.</p>	

Effective

Rating: Requires improvement

At the last inspection in January 2017, we rated the practice as good for being effective.

At this inspection we have rated effective as requires improvement because:

- Most patients received effective care and treatment that met their needs, but processes to ensure patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported were not always effective.
- There was considerable quality improvement activity, but it had not always been co-ordinated to ensure that it led to improvements in the quality of care.
- The practice was not able to consistently demonstrate that staff had the skills, knowledge and experience to carry out their roles.

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

Processes to ensure 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 were not consistently effective.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial ¹
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial ³
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial ⁴
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial ²
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
The practice prioritised care for their most clinically vulnerable patients.	Y

Explanation of any answers and additional evidence:

Effective care for the practice population

Findings

- 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.
 - Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
 - There were staff designated to supporting the care of patients with a learning disability. 100% of patients with a learning disability received an annual health check in the last 12 months.
 - 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.
 - Patients with poor mental health, including dementia, were referred to appropriate services.
 - A research nurse was based in the practice 3 days a week and patients who gave consent benefitted from involvement in nationally- managed clinical trials to improve care and treatment.
1. Staff told us that they received updates to evidence-based practice at meetings and that updates were attached to minutes for those who could not attend. We did not see an example of this.
 2. We reviewed the records of 5 patients on a medicine that can be over-used. Of these 2 patients had not received the review for their usage that would be expected.

Management of people with long term conditions

Findings

3. Searches of clinical records identified 22 patients with blood tests indicating they may have an undiagnosed long-term condition which had not been identified or recorded in their records. Patients not correctly identified might miss review in line with national guidance, consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm.

We reviewed the records of 5 of these records and found 1 was not coded appropriately and 3 were coded very recently (from blood test results received some time ago). One of these had not had a timely repeat test to confirm his medical condition.

The practice told us that if a patient has blood test results in the pre-diabetic range they send a text with lifestyle information, and the patient record is then automatically coded to receive reviews and ongoing monitoring. The practice told us that this system had been introduced in approximately 2020 and the patients that we identified as not having received timely coding dated from before this was introduced, because there was not an audit to check which patients still needed manual follow up at the time of implementation.

4. The practice had 1075 patients with diabetes and 82 with a complication of diabetes that affects the eyes. We looked at the records of 5 of these patients and found that 1 patient had not been followed up in line with national guidance to ensure they received appropriate care.

The practice told us that they were strengthening the systems for patient follow up with the recruitment of a recall manager and that all blood test results for diabetes (HbA1c) would be reviewed by the practice diabetic leads to improve the response to any blood test results that need follow up.

- 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.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.

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 influenzae type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	162	170	95.3%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	169	204	82.8%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	169	204	82.8%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	170	204	83.3%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	217	250	86.8%	Below 90% minimum

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

Any additional evidence or comments

The practice sent invitations for childhood immunisation via text messages, telephone calls and letters, but was finding that there was a low response rate. Appointments for childhood immunisation were offered (for pre-booking) during normal opening hours, and in the evenings and on Saturdays.

The practice showed us data that indicated an improvement in some of the childhood immunisation indicators. Practice data cannot be directly compared to the nationally validated data. The practice told us that it was planning to look at new strategies to improve uptake, for example, direct booking from a text message, with the recruitment of a dedicated recall manager.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	69.5%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	68.9%	N/A	70.3%	N/A
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). (12/31/2022 to 12/31/2022) (UKHSA)	72.7%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	66.2%	53.7%	54.9%	No statistical variation

Any additional evidence or comments

The practice contacted patients who were due to receive cervical screening. Cervical screening was also offered at the local specialist hub clinics.

The practice showed us data that indicated improvement in the uptake of cervical screening. Practice data cannot be directly compared to the nationally validated data.

The practice was planning to look at new strategies to improve uptake, for example, direct booking from a text message, with the recruitment of a dedicated recall manager.

Monitoring care and treatment

There was considerable quality improvement activity, but it had not been co-ordinated to ensure that it led to improvements in the quality of care.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>We asked the practice for clinical audits or other improvement activity in the last 2 years.</p> <ul style="list-style-type: none">• Most of the examples we were sent were first audits/quality improvement activities, which assessed an aspect of care without a second activity to demonstrate action that had to improvement.• We were sent a complete audit (one with both a first and second stage) for cancer diagnoses but the second audit had only data with very limited discussion and no future actions noted.• There were complete audits for antibiotics prescribing, which were requested by the practice commissioners, and showed improvement in some indicators. <p>We asked the practice if there were more examples of clinical audit and quality improvement activity, including any in the last 3 years and were sent:</p> <ul style="list-style-type: none">• some further first audits/quality improvement activities• complete audits on antibiotics and on prescribing of a medicine used to prevent blood clots, which were requested by the practice commissioners, and showed improvement in some indicators• complete audits on monitoring of patients prescribed medicine to treat an underactive thyroid and on monitoring patients at risk of diabetes, which showed some improvement, but to below the expected levels.	

Effective staffing

The practice was not able to consistently demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y ¹
Staff had protected time for learning and development.	Partial ²
There was an induction programme for new staff.	Partial ³

Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial ⁴
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N ⁵
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> Staff told us that the practice encouraged learning and development. We were given examples of staff members who had been supported to develop their skills and move into new or expanded roles. Staff told us that they did not always have protected time for learning and development, but where they did not have time to complete required learning and development in working hours they were given paid time out of normal hours to complete it. There was an induction programme for new staff. We looked at the records of three staff members. There was no induction on file for one staff member. Before the inspection we asked the practice to tell us when staff had last received an appraisal. From the information received, there were 40 staff who had been in post for more than 12 months, and only 25 had received an appraisal in the last year. The practice explained that there had been a period of turbulence caused by transition between practice managers and that as a result there had been delays in appraisals, but that these had now been completed. <p>The practice had introduced a system of monthly formal clinical supervision. Almost all clinical staff had participated in a recent clinical supervision session.</p> <ol style="list-style-type: none"> The practice carried out audits of cervical screening sample taking every 6 months, including of whether all smear takers are taking at least 8 samples per month in order to maintain competent. We looked at 3 audit reports (January – July 2022, July – December 2022 and January – July 2023). The earliest audit we saw found that one sample taker had not taken 8 samples per month, because of changes to staffing. This issue was repeated on the two subsequent audits. The audits also reviewed the number of samples returned as being inadequate/insufficient. In the most recent audit this was noted as low at 0.7%. The audit did not consider that because of difference in the number of samples taken by different staff, although one staff member only had 1 inadequate sample, this represented 5% of samples they took. 	

Coordinating care and treatment

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

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

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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 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
Explanation of any answers and additional evidence, including from clinical searches:	
We looked at 3 examples of where a DNACPR decision had been recorded. We saw examples of patients' views being sought and respected. However in some cases, for example where the decision had been taken in hospital, it was not possible to assess the decision making process as a copy of the form had not been saved on the patient record.	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was generally positive about the way staff treated people, with above average satisfaction with healthcare staff recorded on the National GP Patient Survey.

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

Patient feedback	
Source	Feedback
NHS.uk website (formerly NHS Choices)	9 reviews in last 12 months: all wholly positive. Patients who comment on staff described them as helpful and efficient.
Feedback to CQC	6 patients contacted CQC in last 12 months: <ul style="list-style-type: none"> - 2 patients contacted us with concerns about clinical care, staff attitudes and appointment access (prior to the practice changing the booking system). - 4 patients contacted us with positive feedback (after we arranged for a feedback link to be placed on the practice website for the inspection). These patients told us that appointment booking worked well and that staff were helpful and supportive.

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)	90.5%	87.0%	85.0%	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	92.1%	85.1%	83.8%	Tending towards variation (positive)

professional was good or very good at treating them with care and concern (01/01/2023 to 30/04/2023)				
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 (01/01/2023 to 30/04/2023)	100.0%	93.8%	93.0%	Significant variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	79.5%	76.4%	71.3%	No statistical variation

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

Any additional evidence
The practice had planned to carry out its own patient survey but had not yet done so due to delays in getting access to a survey tool.

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

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023)	100.0%	91.3%	90.3%	Significant variation (positive)

	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.	2.4% (398 patients)
How the practice supported carers (including young carers).	The practice sent carers texts to inform them of eligibility for vaccinations. Carers were offered annual health checks and referral to support organisations. There was information on the practice's website which directed carers to local support services.
How the practice supported recently bereaved patients.	The practice had a specific policy covering actions to take following the death of a patient. This included contacting patients to offer condolences and support, reporting requirements and steps to avoid causing distress by sending letters and messages about a deceased family member's removal from the practice list. We also saw information about support services on the practice website.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:	

Responsive

Rating: Requires improvement

At the last inspection in January 2017, we rated the practice as good for being responsive.

At this inspection we have rated responsive as requires improvement because:

- The practice had made changes to how it organised and delivered services to try to better meet patients' needs. Information as to the impact was incomplete, and it had not assessed whether the changes had made it harder for some patients to access services.
- The practice had not complied with the Accessible Information Standard as patients were not asked on registration about any information and communication needs and how these could be met.
- Until recently the practice had not responded to complaints in line with national guidance and there was mixed evidence as to the extent that complaints were used to improve the quality of care.

Responding to and meeting people's needs

The practice had made changes to how it organised and delivered services to try to better meet patients' needs. However it had not assessed whether this had made it harder for some patients to access services.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Partial ¹
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.	Partial ²
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	N ²
Explanation of any answers and additional evidence: 1. Please see information about access to services (below). 2. The practice had made reasonable adjustments for patients who found it hard to access services, and these were clearly recorded on patient records. The practice was planning to become a member of scheme through which organisations commit to supporting people who are living with non-visible disabilities. However, the practice registration form did not ask patients if they had any information or communication needs or how these needs can be best met (meaning that the practice did not meet the Accessible Information Standard). We saw examples of complaints from patients who found it hard to access services because of their disabilities and did not see any evidence that reasonable adjustments had been considered.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am - 6pm
Tuesday	8am - 6pm
Wednesday	8am – 7.30pm
Thursday	8am - 6pm
Friday	8am - 6pm
Alternate Saturdays	8.30am - 11.30am
Appointments available:	
Monday	8.15am – 5.50pm
Tuesday	8.15am – 5.50pm
Wednesday	8.15am – 5.50pm, 6.30pm – 7.30pm
Thursday	8.15am – 5.50pm
Friday	8.15am – 5.50pm
Alternate Saturdays	8.30am - 11.30am

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. • In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred. • The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues. • The practice was open on alternate Saturday mornings for pre-booked appointments. 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. Appointments were available on weekday evenings 6.30pm until 8pm and on Saturday and Sunday 8am until 8pm. • 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

The practice had made changes to the appointment system to reduce the time people waited for appointments. Information as to the impact was incomplete, particularly on people who might have additional need to pre-book.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Partial
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Partial
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice changed their appointment system in July 2022. Appointments with nursing team, pharmacists and physios could be booked in advance but almost all (90%) of GP and physician associate appointments were available only to book on the day. The change was made in response to increasing wait times for routine appointments and high rates of patients who did not attend (DNA) for their booked appointments. • At the same time as changing the appointment system, the method for booking appointments was changed. 60% of same day appointments were available to book online, released at 7am and 1pm. 40% were available to book by telephone or for patients visiting the practice at 8am or 2pm. The practice recognised that there were sometimes long waits for people trying to call the practice – sometimes longer than 20 minutes. The practice was expecting to receive a new cloud-based telephone system within weeks that would increase flexibility and improve monitoring. • Following these changes the practice had found improvement in DNA rates and on reception staff morale. However there had not been any practice-based survey to assess the impact on patient satisfaction. Some staff members told us that some patients, particularly older people, seemed to be finding the changes difficult and were finding on-the-day appointments did not meet their needs so well as pre-booking. • 10% of GP appointments were available to pre-book in advance. Some of these were used by GPs to book in some patients who needed follow up appointments, particularly if being seen for their mental health. We heard different accounts as to whether other clinical staff, such as nurses and pharmacists, could pre-book GP appointments for patients they felt needed review by a doctor. • Some patients had clear notes on their records that told reception staff that they should be booked into one of the advance appointments on request, for example to accommodate additional support for a disability. However there was no systematic approach to ensuring that patients who might have additional need to pre-book were identified. The practice had registers of patients who for various reasons were considered vulnerable, but not all of these had been considered for eligibility to pre-book 	

an advance appointment on request. Patients with learning disabilities or their carers, for example, could not pre-book advance appointments. Reception staff were able to use the advance booking slots for these patients if the practice wanted to see them following test results. We saw examples of complaints from patients who found it hard to access services because of their additional needs and did not see any evidence that reasonable adjustments had been considered.

- Appointments during the practice extended hours (Wednesday 6.30pm - 7:30pm and Saturday mornings) and on weekday evening and weekends at additional locations within the area could be booked in advance by telephone.
- All staff told us that patients coded as vulnerable would be prioritised for an appointment or review by the duty GP on the same day. There was a system to redirect patients who've asked for an appointment with a GP to other appropriate staff (e.g. a pharmacist or physiotherapist) by using information given in online bookings or on the telephone, to free slots for other patients with urgent clinical needs.
- There was information on the practice telephone message and website about how to access services, but this was not very clear as to the different options available and the appointments available for pre-booking for patients that found this more convenient. The practice had added the GP rota to the website to support patients who wished to request an appointment with a specific GP.

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023)	38.9%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	59.8%	61.8%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	43.4%	59.4%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	74.3%	73.3%	72.0%	No statistical variation

Any additional evidence or comments

- The practice planned to do a patient survey before and after implementing the new phone system.

- The practice also planned to introduce an online triage tool and was reviewing options. The partners told us that they envisage further changes to the appointment booking system at that point (e.g. to allow patients to book appointments in advance, in line with the clinical priority suggested by the triage tool).

Source	Feedback
NHS.uk website (formerly NHS Choices)	9 reviews in last 12 months: all wholly positive. One commented directly on the experience of the online booking system.
Feedback to CQC	6 patients contacted CQC in last 12 months: <ul style="list-style-type: none"> 2 patients contacted us with concerns about clinical care, staff attitudes and appointment access (prior to the practice changing the booking system). 4 patients contacted us with positive feedback (after we arranged for a feedback link to be placed on the practice website for the inspection). These patients told us that appointment booking worked well and that staff were helpful and supportive.

Listening and learning from concerns and complaints

Until recently the practice had not responded to complaints in line with national guidance and there was mixed evidence as to the extent that complaints were used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	32
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	1
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.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> NHS providers are expected to follow national guidance which says complaints should be acknowledged within 3 working days. At the time of the inspection the complaints policy on the practice website was not in line with this guidance as it said that an acknowledgement would be sent if there would be a delay in responding, in which case an acknowledgement would be sent within 7 days. Staff told us that the complaints policy had been updated quite recently to bring it in line with national guidance. We looked at the practice log of complaints. <ul style="list-style-type: none"> The 2022- 2023 log showed that 16/52 (31%) complaints were not acknowledged within 3 working days. The majority had not been handled in line with the practice policy as patients did 	

not receive an acknowledgment even if responses were sent more than 7 days after the complaint was received.

- The 2023 – 2024 log showed that 3/15 (20%) complaints were not acknowledged within 3 working days and 2/15 were not acknowledged within 7 days. The most recent complaints were acknowledged in line with national guidance.

Example(s) of learning from complaints.

Complaint	Specific action taken
There were 3 complaints about difficulties that patients with additional access needs were caused by not being able to pre-book.	We looked at one of these complaints. We found that the patient had been booked an appointment to resolve the immediate issue. However the patient had not then been coded to allow for pre-booking in future and there was no evidence that this had been considered, or evidence of wider assessment of how some patients might be impacted by the change to most GP appointments being available only on the same-day.
A complaint about the length of time taken to provide information from patient records.	The practice reviewed the process for providing information to take into account the need for speed when information was requested for an urgent need.

Well-led

Rating: Requires improvement

At the last inspection in January 2017, we rated the practice as good for being well-led.

At this inspection we have rated well-led as requires improvement because:

- Leaders had identified the challenges to quality and sustainability and had taken actions to address them, but had not always fully assessed the impact.
- There was evidence that some governance systems had not worked effectively, particularly those to manage risk and there was no effective overall oversight mechanism.

Leadership capacity and capability

Leaders had identified the challenges to quality and sustainability and had taken actions to address them, but had not always fully assessed the impact.

	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.	Partial
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: The practice leaders had identified and reflected on the challenges and had made changes to how it delivered care in response to challenges, including broadening the range of clinical staff in the practice and how appointments were arranged, but had not always fully assessed the impact on people who are more likely to have a poorer experience of care.	

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

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	

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

Source	Feedback
Practice staff survey	The practice had carried out their own survey of staff in the last 12 months. The survey was shared with all staff and 54% replied. Staff reported clear roles, high levels of satisfaction with opportunities for professional growth, support and learning opportunities. Staff reported that communication within the practice was generally good, although sometimes more difficult between teams.
Feedback to CQC	Staff gave similar feedback to CQC to that in the staff survey. Staff told us that they felt supported and enjoyed helping patients receive the best possible care. Relationships across the practice were described as good, although there were some feedback that although communication within teams was between teams was sometimes less effective.

Governance arrangements

There were governance structures and systems but they had not been consistently effective and there was no effective overall oversight mechanism.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial

Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There were governance structures and systems in place but there was no regular or consistent review to ensure the structures and systems were operating effectively. We found that some had not been consistently effective for some time, although changes had been made recently to improve. For example, related to risk management and complaints handling. • Some policies had not received regular review to ensure they were still in line with national guidance. For example, we noted gaps of 7 years between reviews of the significant event policy. Some policies lacked detail, for example about female genital mutilation. • Until recently some policies were not in line with national guidelines and there was not an effective mechanism to ensure that policies were consistently followed, for example on handling complaints. • Staff told us that policy and process documents were hard to find. The practice had started to transfer files onto an online document storage system designed for GP practices. 	

Managing risks, issues and performance

At the time of the inspection, the practice did not have consistently effective processes for managing risks, issues and performance. We noted changes made during the inspection process and plans to improve further.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	N
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> <ul style="list-style-type: none"> • At the time of the inspection, the assurance systems in place were not comprehensive and were not all subject to regular review. 	

- There was considerable quality improvement activity but it was not all well-coordinated to ensure it improved patient care. Quality improvement work had not, until recently, identified weaknesses in the practice systems and processes.
- Policies and processes for identifying, managing and mitigating risks did not all operate effectively, particularly those for risks related to fire, infection prevention and control, recruitment, medicines and long-term conditions management.
- Discussion of significant events to track learning and actions identified during the assessment process was not well-recorded.
- The mechanisms for monitoring actions arising from different sources was not consistently effective as they were not all well-recorded and were not routinely followed up as part of the governance process.
- Following the site visit the provider shared detailed plans for a clear, documented system to strengthen the practice leaders' oversight, including of risk.

Appropriate and accurate information

The practice information to support decision making.

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

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
Staff are supported to work remotely where applicable.	Y

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.	Partial
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had produced an action plan for the 2022 national survey (published June 2023) but had not shared with with the Patient Participation Group until after January 2023. 	

Feedback from Patient Participation Group.

Feedback
<p>The Patient Participation Group (PPG) representative told us that there were regular meetings with good engagement from practice staff.</p> <p>The PPG representative told us that the practice shared information and involved the group in their plans for changes and improvements.</p> <p>We heard feedback from the PPG that the changes to appointment booking had improved the wait to get through by telephone a bit and that further improvement was anticipated with the new telephone system.</p>

Continuous improvement and innovation

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

	Y/N/Partial

There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence:	

Examples of continuous learning and improvement

The practice was involved in local initiatives to improve care with other local practices and with secondary care.

Within the practice they had made changes to some systems and processes and where partners were looking at other ways to improve both services offered to patients and the internal processes. Staff were involved in process review through task-and-finish groups as well as discussion in standard meetings.

However, although there was considerable quality improvement activity, quality improvement had not been coordinated to ensure that it led to improvements in the quality of care, it had not identified and addressed weaknesses in some systems and processes and some changes had not been fully assessed.

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.