

# Care Quality Commission

## Inspection Evidence Table

### Medlock Medical Practice Dr Hossain & Dr Chauhan (1-538863375)

Inspection date: 13 September 2022

## Overall rating: Requires improvement

We carried out an inspection at Medlock Medical Practice Dr Hossain and Dr Chauhan on 13 September 2022. We have rated the practice as requires improvement overall. The key questions of safe, responsive and well-led have been rated requires improvement, the key questions of effective and caring have been rated as good. We found a breach of Regulation 17 (good governance).

## Safe

## Rating: Requires improvement

The key question of safe was rated requires improvement: Medicine reviews were completed without patient involvement and without all the required checks being carried out; The system for learning and making improvements when things went wrong was not effective. Feedback from staff included that clinicians did not always have the equipment they required.

### 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

<b>Safeguarding</b>	<b>Y/N/Partial</b>
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:	
<ul style="list-style-type: none"> <li>• Staff had access to safeguarding e-learning modules. All staff members had completed safeguarding training to the appropriate level for their role.</li> <li>• There were safeguarding policies and procedures in place for both children and adults and protocols were in place for patients who did not attend appointments.</li> <li>• The lead GP in the practice attended local adult safeguarding and child protection meetings when required.</li> <li>• The practice monitored all children who did not attend appointments in primary or secondary care. Safeguarding referrals were made when required.</li> <li>• The practice provided us with several examples where they had identified issues and made referrals.</li> <li>• The practice had a process for requesting DBS checks following the completion of a new staff member's probation period. The risk assessment they completed at the start of employment was not always held in the staff personnel files. Following the inspection, the practice sent us evidence a risk assessment had been completed; it had been kept on a central human resources file.</li> </ul>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
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

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 27/07/2022	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 31/08/2021 Actions from fire risk assessment were identified and completed.	Yes

## **Infection prevention and control**

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

	<b>Y/N/Partial</b>
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: 19/07/2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice supplied us with their Infection Prevention and Control Policy. This was from Beacon GP Care for the organisation Medlock Medical Practice. However, it was not fully personalised as it mentioned a different GP practice in it. The Registered Manager explained that Beacon GP Care was an umbrella company that provided corporate and clinical governance together with an operational structure for individual GP Practices that had decided to join the group.</li> <li>The policy stated that the practice worked in conjunction with South Manchester Clinical Commissioning Group (CCG). This was inaccurate. Prior to Integrated Care Boards taking over the functions of CCGs in April 2022 the practice was a member of NHS Oldham CCG.</li> <li>Following the inspection, the Registered Manager told us they had provided us with an archived policy and supplied us with the one stated to be in use. However, the policy stated to be in use was dated prior to the policy initially supplied so it was unclear how the policies had been managed.</li> </ul>	

## Risks to patients

**There were adequate 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.	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

## 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. <sup>1</sup>	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

## Appropriate and safe use of medicines

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

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

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)	0.89	0.91	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)	5.3%	7.2%	8.8%	Tending towards variation (positive)
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)	4.38	4.43	5.29	Tending towards variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	158.8‰	187.3‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group	0.71	0.86	0.60	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) <small>(NHSBSA)</small>				
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) <small>(NHSBSA)</small>	7.4‰	7.3‰	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).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. <sup>1</sup>	Partial
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. <sup>2</sup>	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
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
Explanation of any answers and additional evidence, including from clinical searches.	

Medicines management	Y/N/Partial
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As part of our inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor without visiting the practice. The records of patients prescribed certain high-risk medicines were checked to ensure the required monitoring was taking place. These searches were visible to the practice:

- The records we examined provided evidence that the majority of patients prescribed high risk medicines had been monitored appropriately.
- We saw evidence that the practice carried out regular audits on high risk medicine monitoring. Four-weekly searches were carried out for some medicines and we saw there were three cycles of audits each year to monitor patients prescribed high risk medicines.
- The practice had been proactive in reviewing the patients who were taking medication with addiction potential.
- The provider checked all cases where we identified monitoring could be overdue. Some of these patients were booked in for their blood tests, and for others they were able to evidence the contact the practice had made to encourage patients to attend their monitoring appointments.
- Medication reviews were not always of good quality. We saw some structured medication reviews were coded without the patient contact, and some were coded as completed but monitoring was not up to date.
- The practice had a notice displayed on the medicine fridges to remind relevant staff of the need for a Patient Group Direction (PGD) or Patient Specific Direction (PSD).
- The Registered Manager and senior partner told us in order to make the clinical rooms flexible and able to be used by any GP, they had 'hot boxes'. These were boxes that contained the medical equipment a GP would need for their surgeries. As part of the inspection we received feedback from staff, including clinicians. Clinical staff told us the hot boxes were for medical students only. They stated salaried GPs were not always able to access the equipment they required, and when it was provided it was difficult to locate because of the inconsistent organisation within the clinical rooms.

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

**The practice did not have a 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.	Partial
There was a system for recording and acting on significant events.	No
Staff understood how to raise concerns and report incidents both internally and externally.	No
There was evidence of learning and dissemination of information.	No

Number of events recorded in last 12 months:	Four
Number of events that required action:	Four
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice recorded 'significant events' and 'learning events'. The Registered Manager told us the partners decided if an incident was a significant event or a learning event. Guidance from the General Medical Council (GMC) recognised that different terms could be used for these events and some organisations may have refined the term more broadly to include learning events other than those that resulted in harm.</li> <li>• The practice provided us with their significant events policy. Although Medlock Medical Practice was recorded on the first page, a different medical practice was mentioned in the document.</li> <li>• In the previous 12 months the practice had recorded one significant event and three learning events. There had been no significant events recorded between 15 June 2021 and 29 June 2022. The three learning events had been recorded since 16 June 2022.</li> <li>• We asked the Registered Manager if there was a policy for learning events. They told us that there was no policy, but they thought one would be beneficial to differentiate between significant events and learning events, and they would put one in place following the inspection.</li> <li>• Learning events were recorded and could be viewed on Clarity Teamnet. Clarity Teamnet is a sharing, compliance, and workforce management platform for GP practices and practice groups. The Registered Manager told us it was unusual to have learning events at this practice as they were usually dealt with before they progressed to a learning event.</li> <li>• Following the inspection, the senior partner told us that learning events came out of complaints; the learning event was the investigation. They told us that once the outcome had been reached the learning event was uploaded onto Clarity Teamnet for staff to read. All of the three recorded learning events had been from complaints. The practice's complaints policy, which had been reviewed in June 2022, made no reference to learning events.</li> <li>• Some complaints had been made to the practice that had not been recorded as learning events.</li> <li>• There was a lack of clarity about what should be recorded as a significant event, learning event or complaint. Significant/learning events and complaints was an agenda item in clinical meetings. We saw minutes stating that there had been a complaint but no significant/learning events. However, this had been formally recorded as a learning event. Discussions around the incidents were not recorded in meeting minutes.</li> <li>• One of the clinicians described a recent significant event/learning event. However, this was not included in any of the documentation we saw in the evidence supplied by the practice or on Clarity Teamnet.</li> <li>• We received feedback from clinical team members as part of the inspection. We were told that although significant/learning events were mentioned in meetings learning is not discussed. They told us that who had been involved in the incident was divulged during the discussion so this could be embarrassing and not encourage reporting.</li> <li>• There were no separate significant event meetings or reviews; any discussion held was in the normal clinical meetings. Clinicians told us that there had been significant events at the practice that had not been recorded in the previous 12 months, and these related to clinical issues. The senior partner told us they did discuss issues in meetings, but they may not be formally recorded as learning events. They said they did not want to make them up for the sake of it.</li> <li>• The senior partner told us learning from significant/learning events was shared by a regular newsletter called 'Knowledge Bites'. This was compiled by a clinical pharmacist from Beacon GP Care. Clinicians at this practice received these newsletters. We had feedback from clinicians that these were helpful, but they told us they were for sharing the results of clinical audits and other clinical information, and significant/learning events were not included. The Knowledge Bites we reviewed did not contain information about significant events.</li> </ul>	

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Examples of significant events recorded and actions by the practice.

Event	Specific action taken
August 2022. A home visit booked for a patient with specific health and care needs was not carried out. The visiting clinician been unable to find the address. No call had been made to inform the patient or their carer.	An apology was made and the home visit rearranged. The documented learning was that communication could be improved.
July 2022. A patient did not feel supported by the practice when they requested help understanding how to use a medical device.	There was a delay in responding to the patient's request and then they were signposted elsewhere. The documented learning was that communication could have been more effected, and it was recorded that the practice could have empathised more.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. <sup>1</sup>	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had a process in place for safety alerts to be reviewed. A record was maintained of the action taken in response to alerts where appropriate. There was a new role, a pharmacy technician, that listed the alerts and the action that was required.</li> <li>• The practice's medicine management team carried out monthly audits to ensure that alerts had been implemented.</li> <li>• We looked at the MHRA alert for Teratogenic medicines. These can cause foetal abnormality. Four patients had been informed of the risks recently and the fifth had been informed previously and had recently been sent a message informing them of the risks.</li> </ul>	

## 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. <sup>1</sup>	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. <sup>2</sup>	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated. <sup>3</sup>	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

### Effective care for the practice population

#### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- 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.

- We saw evidence that patients receiving end of life care had care plans in place that were regularly reviewed. Patients were given a pack that contained useful information and telephone numbers.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- We saw patients with conditions such as diabetes and chronic kidney disease (CKD) were being monitored appropriately and had good quality reviews of their condition.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared information with relevant professionals when deciding care delivery for patients with long-term conditions.
- A team from Beacon GP Care Ltd carried out monthly chronic condition searches on behalf of the practice to review patients with conditions such as CKD, diabetes and hypertension. Beacon GP Care was an umbrella company that provided corporate and clinical governance together with an operational structure for individual GP Practices that had decided to join the group.
- The pharmacy team from Beacon GP Care carried out an audit to identify patients with asthma who overused their inhalers. They sent a link to patients with a video explaining how to better control their asthma, and asked them to book an appointment with the practice nurse to discuss their condition.
- Patients with asthma were offered an asthma management plan.
- The practice had 'make every contact count' template for use by the practice nurses and healthcare assistant. This was to prompt all necessary observations and investigations to be carried out at the initial contact with the patient.
- As part of the inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor. The records of patients with long term conditions were checked to ensure the required assessment and reviews were taking place. These searches were visible to the practice. The records we examined provided evidence that overall patients with long term conditions had been monitored and reviewed appropriately. Where our searches identified gaps, the practice immediately reviewed them and provided evidence of action taken.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	42	53	79.2%	Below 80% uptake
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)	37	49	75.5%	Below 80% uptake
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)	37	49	75.5%	Below 80% uptake
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)	37	49	75.5%	Below 80% uptake
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)	33	48	68.8%	Below 80% uptake

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

### Any additional evidence or comments

At the inspection the practice provided us with unverified evidence that all their childhood vaccination rates were at 100%. The practice told us this was regularly monitored.

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)	71.6%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	50.9%	58.3%	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)	56.4%	58.7%	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)	50.0%	50.5%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments
<ul style="list-style-type: none"> <li>We asked the practice for their latest cervical screening data. We saw that in September 2022 the unverified data was that 65% of 25 to 49 year olds and 75% of 50 to 64 year olds had been adequately screened. The practice told us they had a plan in place to meet the target and they now had sufficient staff to carry out cervical screening.</li> <li>The practice told us they were working on their cervical screening data. They had held a women's day focusing on women's health and they thought having a weekend clinic was the best way to encourage patients to attend.</li> </ul>

## 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

- The practice provided us with many examples of their ongoing clinical audit programme, and the positive outcomes evidenced from their audits.
- The practice carried out an audit on patients who attended A&E within GP practice opening hours.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	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.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes

Explanation of any answers and additional evidence:

- We saw that training was monitored and all staff had completed mandatory training courses.
- New staff had regular reviews with their manager, initially at the one, three and six month stage, before having annual appraisals.
- Audits were carried out on 1% of GP consultations each month. We saw that results were positive.
- Clinicians told us they did not have any clinical supervision and did not always feel supported.

## 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:

- The practice participated in social prescribing and used resources within the practice and the wider organisation to support.

## Consent to care and treatment

**The practice obtained consent to care and treatment in line with legislation and guidance, but documentation was not fully completed.**

	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. <sup>1</sup>	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Although we saw that DNACPR decisions were made in line with legislation they were not always fully completed.</li><li>• We reviewed three DNACPR decisions that had been made. One of these had been put in place by the hospital and the majority of the form had been completed.</li><li>• The other two DNACPR decision forms we examined stated that CPR was unlikely to be successful, but the reasons were left blank. In both of these the part of the form relating to the decision being reviewed had not been completed; they did not indicate if the decision was indefinite or needed reviewing.</li><li>• Following the inspection, the senior partner told us all patients with a DNACPR decision had a full care plan in place and all relevant information was recorded in the care plans.</li></ul>	

## Caring

**Rating: Good**

### Kindness, respect and compassion

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

	Y/N/Partial	
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes	
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes	
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes	
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice had received the Gold Pride in Practice award. Pride in Practice is a quality assurance support service delivered by LGBT Foundation to ensure that all lesbian, gay, bisexual and trans people have access to healthcare that understands and meets their needs.</li><li>• The practice was an Armed Forces Veteran Friendly accredited GP practice. This supported the health commitments of the armed forces covenant, a national scheme to improve medical care and treatment for former members of the armed.</li><li>• The practice had signed up to the Homeless Friendly pledge. This is a pledge to change the culture of healthcare, public and private sector organisations and society and remove any barriers homeless people may have to accessing services.</li><li>• The practice had recently made a decision to stop sending 'zero tolerance' letters to patients. Zero tolerance letters are sent to patients who display abusive, aggressive or threatening behaviour, to explain how this is unacceptable and the consequence of any repeat abuse. Instead, they introduced 'Be Kind' letters. These had been suggested to the Registered Manager on a recent training course; they asked patients to be mindful about staff feelings and reassured them they were there to help when needed. The practice website still detailed the use of zero tolerance letters.</li></ul>		

## National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	77.6%	80.9%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	79.9%	80.7%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	93.6%	91.0%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	80.7%	63.2%	72.4%	No statistical variation

### Any additional evidence or comments

- The practice had put an action plan in place following the results of the GP Patient Survey.
- This included a plan to improve the score for patients thinking the healthcare professional was good or very good at listening to them, and included actions such as using a 'make every contact count' template. They planned to carry out a patient survey to assess improvements made

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

## Involvement in decisions about care and treatment

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

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

## National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	87.1%	87.7%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Information leaflets were available at the practice. Staff were also able to print off leaflets in other languages or in easy read format when required.</li> <li>The practice sent a congratulations card to new parents. They also sent parents information about healthcare for new babies when vaccinations would be due.</li> <li>Information about support groups was not easily accessible on the website, although some information was in previous news stories. However, there was information available in the practice. This included information on the Homeless Friendly organisation and LGBT.</li> </ul>	

Carers	Narrative
Percentage and number of carers identified.	The practice had 209 carers registered, which was 2.9% of the practice population.
How the practice supported carers (including young carers).	Carers were offered an annual health check and a flu vaccination. The practice asked if patients were carers on their patient registration form. Patients were also periodically sent a text message to ask them if they were a carer so the additional support could be offered.
How the practice supported recently bereaved patients.	Bereaved patients were sent a sympathy card along with useful information if appropriate. They were also offered a consultation or home visit if appropriate.

## Privacy and dignity

### The practice did not always respect patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>There was very limited waiting room space in the reception area. This meant that patients were sat or queued next to patients at the reception desk. We observed that staff were sensitive in the way they spoke with patients and asked them questions, but privacy could not be ensured. The senior partner told us they had plans to expand the area which would help with privacy.</li> </ul>	

## Responsive

## Rating: Requires improvement

The key question of responsive was rated requires improvement: Complaints were not used to improve the quality of care.

### Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>There was very limited waiting room space in the reception area, which affected the privacy of patients speaking at the reception desk.</li> </ul>	

### Practice Opening Times

Day	Time
Opening times:	
Monday	7am – 6.30pm
Tuesday	7am – 6.30pm
Wednesday	7am – 6.30pm
Thursday	7am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	7am – 6.30pm
Tuesday	7am – 6.30pm
Wednesday	7am – 6.30pm
Thursday	7am – 6.30pm
Friday	8am – 6.30pm
<ul style="list-style-type: none"> <li>The practice was open from 7am four days a week for appointments with the practice nurse. However, the website indicated this was three days a week.</li> <li>The practice had carried out a survey around extended opening hours. Patients stated they would prefer earlier opening times, and the practice was hoping to facilitate this, from 6.30am, in the near future.</li> </ul>	

- Seven-day GP access was available at sites throughout the Integrated Care Board (ICB) area at various locations for patients unable to access appointment during the normal opening times.
- An out of hours service was provided by GTD Healthcare.

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional nurse appointments were available from 7am four days a week so patients had access before normal school and working hours.
- Children under the age of five were given an on the day appointment if required.
- Pre-bookable appointments were available to all patients at additional locations within the area, at evenings and weekends.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- The practice told us that all asylum seekers in the area were registered with the practice. There were 200 asylum seekers registered at the time of the inspection and they lived in a hotel over three miles away. The practice identified specific health inequalities for this group of patients and took action to address these:
  - The practice told us patients had difficulty accessing the practice as they did not receive any financial funding so could not use public transport. They decided to carry out weekly visits to the hotel so that the needs of the patients could be met. The practice was contacted each week with a list of patients who wished to have a consultation. There was a dedicated treatment room in the hotel for the practice to use.
  - The practice told us very few of the patients spoke English. They arranged for their clinical pharmacist, who had the relevant skills and spoke several languages, to carry out these weekly visits. This also meant there was continuity of care.
  - The practice told us they carried out health screening using a specific template. They had identified a patient with a serious illness during a visit, and they also administered COVID-19 and flu vaccinations.

## 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	
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

## National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	54.4%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	65.3%	45.3%	56.2%	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 (01/01/2022 to 30/04/2022)	70.8%	48.4%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	73.1%	63.8%	71.9%	No statistical variation

### Any additional evidence or comments

- The practice had positive responses for the National GP Patient Survey for questions relating to access.

## Listening and learning from concerns and complaints

### Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	Seven*
Number of complaints we examined.	Four
Number of complaints we examined that were satisfactorily handled in a timely way.	One
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	None

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• * It was difficult to accurately state how many complaints had been made due to the way they were recorded.</li> <li>• There was no overall co-ordination of complaints, including outcomes of complaints, learning and reviews to ensure they were not completed.</li> <li>• Prior to the inspection the practice supplied us with their complaints policy. This was from Beacon GP Care. Beacon GP Care was an umbrella company that managed for example human resources, medicine management and governance. Approximately 10 GP practices were part of Beacon GP Care, and it helped organisations to work together to share best practice and improve performance. The policy included a definition of a complaint and stated the practice manager had overall responsibility for complaints.</li> <li>• During the inspection we saw Medlock Medical Practice also had a complaints policy that had been reviewed in June 2022. This stated that the operations manager was the complaints lead.</li> <li>• The practice policy stated patients should be encouraged to complain verbally at the reception desk. If a resolution could not be made the complainant should be asked to make a formal complaint in writing, by email, by telephone or in person. The policy stated if a verbal complaint was made a written record should be taken and entered into the complaints folder. It stated a form should be completed by the staff member with all information, including the nature of the complaint. It also stated that any clinical complaint should be sent immediately to the senior partner.</li> <li>• The practice's complaints tracker showed that one complaint had been made in the previous 12 months, from March 2022. This was also the only complaint recorded as a complaint on Clarity Teamnet, the sharing, compliance, and workforce management platform the practice used. Following the inspection, the Registered Manager told us complaints had not yet been fully digitalised.</li> <li>• During the inspection we examined the practice's complaints folder. We found there had been more complaints made in the previous 12 months.</li> <li>• The senior partner told us that any investigation and learning from complaints was documented on 'learning events', and not in the complaints file. We examined the learning events completed by the practice. We saw that the three learning events held for the previous 12 months had risen from complaints.</li> <li>• We saw one complaint of a clinical nature. This had been dealt with but there was no evidence it had been directed to the senior partner, it was not included on the complaints tracker and was not documented as a learning event or complaint on Clarity Teamnet.</li> <li>• We saw a further complaint about a clinician. There was no evidence this had been directed to the senior partner. It was in a file marked 'waiting to be processed' but a final response had been issued. It was not included on the complaints tracker and was not documented as a learning event or complaint on Clarity Teamnet.</li> <li>• A verbal complaint about a clinician had been made in July 2022. This was dealt with by the senior partner the day before our inspection, and the complaint was not upheld. The senior partner told us it would now be recorded as a learning event, but the patient did not want to raise a formal complaint. Information relating to the complaint was made in the patient's clinical record. It is not good practice to do this.</li> </ul>	

## Well-led

## Rating: Requires improvement

The key question of well-led was rated requires improvement: Leaders could not demonstrate they had the capacity to deliver high quality care; We saw examples of policies being inaccurate and not being followed; We saw examples of systems and processes that were not effective, including the process to manage significant events and complaints.

### Leadership capacity and capability

**Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	No
They had identified the actions necessary to address these challenges.	No
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Leaders were not always aware of the risks, issues and challenges in the service.</li><li>• The senior leaders (the Registered Manager and senior partner) told us about the challenges they had faced but they had not identified the issues found during the inspection.</li><li>• Not all staff reported that the leaders were approachable and supportive.</li><li>• We saw evidence that staff were able to progress through the company into leadership roles.</li></ul>	

### 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice had a mission statement: "To support and empower our communities to live healthier, happier and independent lives".</li><li>• Most of the 11 staff we received feedback from told us the practice had a clear vision for the future and they were involved in developing the strategic plan and mission statement.</li></ul>	

## Culture

### The practice culture did not always support high quality sustainable care.

	Y/N/Partial
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.	Partial
The practice had access to a Freedom to Speak Up Guardian.	Partial
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The Registered Manager told us the Freedom to Speak Up Guardian was the senior GP partner. Seven of the 11 staff we received feedback from answered 'Yes' to the question "Is there a Freedom to Speak Up Guardian and instructions on how to contact them?" The Registered Manager told us the senior partner was also the lead for whistleblowing.</li> <li>The learning events and complaints we reviewed or were told of did not demonstrate that people were always given an apology or explanation when things went wrong. Incidents where learning was required were not always discussed.</li> <li>The practice had carried out a staff survey. 38% of respondents stated they did not feel they were rewarded for their dedication and commitment towards their work.</li> <li>The practice had become a Real Living Wage employer from 1 September 2022.</li> </ul>	

## Governance arrangements

### The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No
Staff were clear about their roles and responsibilities.	No
There were appropriate governance arrangements with third parties.	No
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The arrangements for governance were not fully clear and did not operate effectively. Examples of this included: <ul style="list-style-type: none"> <li>The practice's infection prevention and control policy made reference to another GP practice and an incorrect Clinical Commissioning Group (CCG) from a different area. From 1 April 2022 Integrated Care Boards (ICBs) replaced CCGs. Following the inspection, the Registered Manager told us they had provided us with an archived policy in error, and they supplied the policy said to be in use. However, the dates on the two policies indicated both were in use at the same time, so it was unclear how they had been managed.</li> </ul> </li> </ul>	

- The practice provided us with their significant events policy. Although Medlock Medical Practice was recorded on the first page, a different medical practice was mentioned in the document.
- The governance around significant events and learning events was not effective. Not all incidents were formally reported and learning was not always documented or discussed.
- The system for managing complaints was not effective. The policy stated if a verbal complaint was made a written record should be taken and entered into the complaints folder. It stated a form should be completed by the staff member with all information, including the nature of the complaint. It also stated that any clinical complaint should be sent immediately to the senior partner. This was not happening.
- Five of the 11 staff we asked told us they were employed by Beacon GP Care Ltd, not Medlock Medical Practice. Beacon GP Care Ltd provided corporate and clinical governance together with an operational structure for the individual GP Practices who had decided to join the group. The practice provided us with a presentation that explained it was a separate legal entity to Beacon GP Care Ltd. The Registered Manager told us that all staff were employed by Medlock Medical Practice.
- The practice's new registration document stated there was a strict Did Not Attend (DNA) policy. If a patient did not attend two appointments without a reasonable excuse they would be removed from the practice list. Information in the practice waiting area was different. It told patients if they did not attend three appointments in a two-month period they would be asked to find a new GP practice.

## Managing risks, issues and performance

**There the practice did not have clear and effective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Partial
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice provided us with a series of audits demonstrating that it regularly reviewed and monitored most clinical risks.</li> <li>Processes to manage other risks, such as those highlighted in complaints and significant events, were not effective.</li> </ul>	

**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

### The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	No
Performance information was used to hold staff and management to account.	No
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The system of recognising, recording, monitoring and learning from significant events, learning events and complaints was not effective.</li> <li>Where complaints or significant/learning events had highlighted areas where improvements could be made by staff members we saw no evidence this had been monitored.</li> </ul>	

## 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 (PPG).	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:	
<ul style="list-style-type: none"> <li>• The practice had an established PPG that met approximately every three months. Seventeen patients had attended the last meeting held in August 2022, and minutes were kept.</li> <li>• The practice had carried out a staff survey. Results were mostly positive. However, 38% of respondents said they did not feel valued for their contributions. We saw that 50% of respondents said management involved them while taking leadership decisions. The practice told us they were a Real Living Wage accredited employer from 1 September 2022.</li> <li>• Beacon GP Care Led held a senior leadership team away day in May 2022 and leaders from the practice attended.</li> </ul>	

## Continuous improvement and innovation

**There was some evidence of systems and processes for learning, continuous improvement and innovation, but learning was not shared.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	No
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The significant/learning events and complaints we reviewed did not provide evidence of learning being shared. Discussion was not included in meeting minutes, and the senior partner told us information was only included on Clarity Teamnet when the events/complaints were closed.</li> <li>• The practice told us they were introducing an on-line consultation platform in September 2022 to improve access for patients.</li> <li>• Beacon GP Care Ltd sent all clinicians a regular newsletter called 'Knowledge Bites'. This was compiled by a clinical pharmacist to share the results of clinical audits and other clinical information. Clinicians at this practice received these newsletters.</li> </ul>	

## 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 practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

## Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **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.
- $\text{‰}$  = per thousand.