

Care Quality Commission

Inspection Evidence Table

Hollyns Health and Wellbeing (1-540404119)

Inspection date: 22 and 23 June 2022

Date of data download: 13 June 2022

Overall rating:

Following an inspection on 17 May 2016 the provider was rated as good overall and good in all five key questions. At this inspection on 22 and 23 June 2022 we rated the practice as requires improvement overall. We rated the provider as inadequate for providing safe services and as requires improvement for providing effective, responsive and well-led services. We rated the provider as good for providing caring services. We found the provider did not consistently demonstrate the delivery of safe, responsive and effective care to all their patients. There were gaps in the practice systems to manage risks to patient safety. This included a lack of oversight in the management of medicines, health and safety issues, and infection, prevention and control. Care and treatment was not consistently delivered in line with current evidence-based guidance and feedback from patients was mixed.

Safe

Rating: Inadequate

At the inspection on 17 May 2016 the provider was rated as good for providing safe services. At this inspection on 22 and 23 June 2022 we rated the provider as inadequate for providing safe services. The provider's systems for the management of medicines, including medicines optimisation were not effective, appropriate or safe. Additionally, a number of actions were required to ensure the safe management of the premises and the environment.

Safety systems and processes

The practice did not consistently demonstrate 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.	Partial
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

Safeguarding	Y/N/Partial
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
<p>A number of policies were in place to support and safeguard vulnerable children and adults. During our inspection we reviewed safeguarding training levels with the provider and found that not all staff were trained to the appropriate level, in line with guidance. The provider immediately responded to our concerns and following the inspection we received confirmation that staff were trained to the appropriate level.</p> <p>All staff at the practice were 'prevent' trained. This training programme aims to give staff the skills to safeguard vulnerable people and recognise when they are at risk of being drawn into terrorism.</p> <p>Vulnerable children and adults were regularly discussed at multidisciplinary meetings (MDT) and this was evidenced in the patient record. We also saw examples of where clinical and non-clinical staff had gone above and beyond to ensure the safety of patients who were vulnerable. The safeguarding lead prioritised the needs of patients and attended whole day safeguarding and MDT meetings. Additionally, a member of the patient services team had recognised a patient who was isolated and at risk when they managed to contact the practice by telephone, but could not speak. The staff member had taken timely action to ensure the patient was safe and their needs were met.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	No
The provider maintained a record of the hepatitis B vaccination status of clinical staff. Following the inspection, they told us they would widen this to include non-clinical staff and a review of the relevant guidance had been undertaken.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Yes
There was a fire procedure.	Partial
Date of fire risk assessment: 17/05/22 (Allerton branch site) 22/01/21 (Clayton location) Actions from fire risk assessment were identified and completed.	Partial
<p>We saw that the provider had undertaken numerous actions following the fire risk assessment, but for more costly and significant works they experienced challenges agreeing a way forward with the landlord of the building, regarding completing necessary works at the Allerton site. This included actions highlighted on the fire audit which had identified that fire breaks were not in place in the roof space as required. The provider had met with the landlord and a surveyor to attempt to resolve this issue.</p> <p>Information was available for staff to direct to the best course of action in the event of a fire, but a fire policy was not in place which detailed the ongoing management of fire safety or how incidents should be reported and responded to. Following our inspection, a newly developed fire policy was shared with the practice team and forwarded to CQC.</p>	

Legionella risk assessments had been undertaken in March 2020 across both sites. The risk assessment indicated that action was required at both sites with immediate effect. The assessment noted there was a significant risk of exposure to legionella bacteria, and identified a number of measures that should be urgently addressed. A member of the management team told us of the actions which had been undertaken by the team such as the flushing of infrequently used outlets weekly and monitoring of water temperatures. No further action had been taken in response to the reports and the team told us they had not been able to move the concerns forward with the landlords of the buildings. No further plans were in place to address these issues.

We also saw that the access from the car park at the Allerton site was via a high gradient slope, which could present issues for people who were less mobile or using wheelchairs or mobility scooters. Other issues at the site identified by the provider included the management of antisocial behaviour and external building issues.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 23/03/21	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>On the day of our inspection, practice training records evidenced that five staff were out of date with their infection prevention and control training (IPC) including both clinical and non-clinical staff.</p> <p>During the inspection we observed rooms were cluttered to a degree which would make appropriate cleaning difficult and pose an infection risk to patients. For example, there were a significant number of items of stock and equipment stored in the minor surgery room and on shelves which were above head height. Following our inspection, the provider immediately responded to these concerns and we were sent photographic evidence that rooms had been decluttered to enable appropriate cleaning to take place.</p> <p>Cleaning schedules for clinical rooms and clinical equipment were not in place.</p> <p>Whilst vaccines were managed correctly, we saw that the interiors of three vaccine refrigerators were visibly dirty on the day of inspection. Following our inspection, we were sent photographic evidence that this had been rectified. We were told that the cleaning of refrigerators would be included in the new cleaning schedules which were to be implemented by the nursing team.</p> <p>We did not see that IPC action plans were reviewed and responded to in a timely manner. For example, actions from an audit dated March 2021 included ordering bins and soap dispensers which had not been completed at the time of our inspection.</p> <p>A number of clinical rooms at both sites had carpeted flooring. A rolling programme of works was in place to change to non-porous flooring. The IPC policy detailed a schedule of carpet cleaning. We also noted damage to walls and floors which would make the management of IPC difficult. The provider was in discussions with the landlords regarding this.</p>	

Risks to patients

Systems were in place to assess, monitor and manage risks to patient safety. However, we did not see these were consistently effective.

	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.	Partial
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
An induction programme was in place to support temporary locum staff. Induction checklists were discussed and given to locum staff. However, these were not completed, signed off or evidenced to the provider.	
All staff had completed sepsis awareness training.	

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Partial
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.	No
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	No
Records which required summarising dated back to December 2021. The practice had identified this as an issue prior to the announcement of our inspection. Additional resources had been agreed to ensure this work was completed. We were told a six week deadline was in place for this work to be completed once a team member was recruited, which was ongoing.	

At the time of our inspection, the provider could not assure themselves of the timely management of test results. For example, we saw that action was not taken in a timely manner in response to blood results or when a follow up was required. We found several examples of patients who required additional or further monitoring which had not been completed, tasks sent for the same, or the necessary action taken. Following our inspection, the provider highlighted a number of concerns to the pharmacy team which provided support for reviews and monitoring to the team via the primary care network. We were sent assurances that any outstanding recalls and tests were being reviewed and patients were being recalled.

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.86	0.82	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)	4.8%	5.4%	8.8%	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)	4.57	4.69	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	177.1‰	120.3‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.37	0.40	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	9.4‰	7.1‰	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

Medicines management	Y/N/Partial
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	No
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.	No
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	No
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.	No
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.	No
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>As part of our inspection, CQC's GP specialist advisor (SpA) undertook a number of in-depth searches of the practice's clinical records system. The searches showed the regular use of a code for medication review without evidence of a full review, any discussion with the patient or any documentation to support the decision made.</p> <p>The clinical searches also found that on numerous occasions where action was required following patient reviews, there was no evidence that this had been carried out.</p> <p>Patients with asthma were not being followed up when they had been prescribed steroids and two patients were not given as steroid card in line with National Institute for Health and Care Excellence (NICE) guidance. Care plans were sent to patients via a text system, but not all clinicians would be</p>	

Medicines management	Y/N/Partial
aware of this as it was not coded. Following our inspection, the provider took action to follow up these patients.	
The searches identified concerns regarding the coding of diabetic patient reviews and their ongoing monitoring. The searches found that some patients had been reviewed by the diabetic specialist nurse, but necessary actions were not followed up as required. The provider took action to review these patients following our inspection.	
The provider had not followed NICE guidance or a drug safety update from 2017 and ensured that the medicines reviews of patients who were prescribed gabapentinoids (a schedule 3 controlled drug) were undertaken annually as required. The practice responded to this concern.	
In addition, on the day of inspection, we saw that recalls, reviews and follow ups for medicines groups including DMARDS (disease-modifying anti-rheumatic drugs) and DOACs (direct acting oral anticoagulants) were not always undertaken in line with clinical guidance. Additionally, 154 patients who were prescribed DOACS required a calculation known as creatinine clearance to be undertaken, which would ensure that the dosage of the medicines, they were taking was correct. Where the clinical searches undertaken by the CQC SpA, identified action needed to be taken due to borderline results, this was discussed with the practice who took action.	
The practice were recalling patients for tests and reviews. Some patient reviews had been put on hold as advised during the pandemic. There had also been a national shortage of blood bottles which had delayed some tests.	
A number of outstanding scans, discharge letters and tasks were identified which required attention. The provider told us they would review these immediately. Following our inspection, we were sent assurances that all outstanding scan results, letters and tasks had been reviewed by a GP and were being managed appropriately.	
The provider had a further meeting planned the week after our inspection to discuss and highlight the concerns regarding the pharmacy reviews with the primary care network (PCN).	
The provider did not have a system in place for the management, storage, distribution and usage of prescription forms.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	10
Number of events that required action:	10
At our previous inspection in 2016, we said the practice should be clear how the lessons learned from incident reports and patient safety alerts were shared in order to improve the safety in the practice. At this inspection, the provider had introduced clear protocols and processes to manage, inform, update and share incidents with staff.	

However, on the day of inspection we saw that duplicate information was held regarding significant events, with outcomes and learning documented on paper but not always recorded on the digital system. The provider told us they would review and streamline this approach.

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

Event	Specific action taken
A patient had inadvertently been changed from one medication to another which caused issues for the patient until the error was noticed.	After completing an incident form and sharing at a practice clinical meeting, it was established that the management of the patient's condition was a learning need for clinical staff. A teaching session was held prior to a practice meeting to help update everyone's knowledge.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Yes
We saw examples of action taken in response to recent alerts. The policy detailed a clear delegation of responsibility for the receiving, dissemination and acting on safety alerts. This included the management of a recent alert regarding disposable wipes. However, documentation was not in place to evidence the dissemination, recording and acting on safety alerts.	

Effective

Rating: Requires improvement

At the inspection on 17 May 2016 the provider was rated as good for providing effective services. At this inspection on 22 and 23 June 2022 we rated the provider as requires improvement for providing effective services. This was because we found care and treatment was not consistently delivered in line with current evidence-based guidance and the practice could not demonstrate how they assured the competence of staff employed in advanced clinical practice.

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 not always assessed, and care and treatment was not consistently 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.	No
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	No
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	No
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
As part of our inspection, CQC's GP specialist advisor (SpA) undertook a number of in-depth searches of the practice's clinical records system. The provider could not demonstrate that they consistently reviewed patients ongoing needs, responded to any further actions required or carried out timely reviews with patients.	
The provider was continuing to manage a number of challenges relating to staff capacity. The team had struggled to recruit and had managed ongoing health absences alongside the COVID-19 pandemic. New members of the nursing team had recently been recruited and the team continued to recruit to other vacancies to increase capacity and enable the timely reviews of patients.	

The provider responded positively to concerns which were raised during our inspection and assured us they would take immediate steps to improve patient care.

The team attended regular meetings and learning sessions each month. Learning needs could be identified by any team member, and we saw that evidence based presentations regarding patient conditions such as hormone replacement therapy (HRT) were held.

Effective care for the practice population

Findings

- The practice team reviewed and responded to guidance during the pandemic and continued to see patients as advised. A RAG rating (red, amber, green) was given to clinical procedures which enabled the patient services team to identify who could be safely seen face to face and where non-contact appointments could be utilised.
- 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 who were frail or nearing end of life were reviewed at multidisciplinary team meetings.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- All patients with a learning disability were offered an annual health check, the practice had completed 52% of their health checks in the last 12 months and continued to recall patients and offer longer appointments to suit individual needs.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. Patients were signposted to additional support from local organisations.
- Patients with poor mental health, including dementia, were referred to appropriate services. We saw several examples of very comprehensive dementia reviews undertaken by an advanced clinical practitioner.

Management of people with long term conditions

Findings

- The practice responded immediately to concerns which were highlighted by the CQC specialist advisor during clinical searches and plans were put in place to respond to these concerns and ensure recalls, reviews and follow ups were in place for patients with long-term conditions.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training and ensured their competencies remained up to date. The practice worked with other professionals to manage the care delivery of these patients. with long-term conditions.
- Patients with mental health issues were offered appropriate assessments. The practice used a number of assessments and pathways to support care.

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were asked to complete seven days of at-home blood pressure monitoring.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	114	123	92.7%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	133	144	92.4%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	131	144	91.0%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	131	144	91.0%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	149	178	83.7%	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

When children were not brought or presented for immunisation, staff at the practice would contact them and offer an additional appointment. If the parent or carer did not respond a letter would be sent. Any

safeguarding issues or repeated non-attendance for childhood immunisations would be discussed with health visitor team and escalated as necessary to the safeguarding lead.

The practice coded non-attenders appropriately and had worked with local community centres to spread positive messages regarding the benefits of immunisation for patients.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	69.4%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	54.2%	52.0%	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)	64.0%	58.5%	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)	65.3%	62.7%	55.4%	No statistical variation

Any additional evidence or comments

The practice had systems in place to offer screening to patients and to recall those who did not attend.

Monitoring care and treatment

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

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

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

The practice reviewed 406 patients who had been offered rapid access clinic appointments and found that 19% of these were deemed to be inappropriate. Following this review, flowcharts were devised for the patient services team to assist in their care navigation of patients, and ensure that patients received appropriate support and care.

We saw that unplanned admissions and attendances at A&E were reviewed in clinical team meetings.

Effective staffing

The practice was not consistently 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.	No
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>On the day of inspection, the provider could not demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, advanced nurse practitioners. Whilst staff were clear that appraisals were undertaken and support was in place, there was no formal review of clinical competence, record keeping or prescribing for some staff.</p> <p>Following the inspection, we were sent evidence that reviews of competence were completed for GP trainees as expected. The practice said they planned to implement regular reviews of all prescribers within the team.</p> <p>The provider had an induction policy in place with a comprehensive induction checklist completed for permanent staff which included ongoing reviews and support.</p> <p>Induction checklists were discussed and given to locum staff. However, these were not completed and signed off and evidenced to the provider.</p> <p>Staff told us that additional support was in place for those returning from long-term absences or maternity leave.</p> <p>On the day of inspection practice training records showed not all staff were trained to the appropriate level in line with guidance and some staff were not up to date with training which was deemed mandatory by the provider. The team immediately responded to our concerns and following the inspection we received confirmation that training had been updated and staff were trained to the appropriate level of safeguarding as required</p>	

Coordinating care and treatment

Staff worked together and with other organisations and were working towards the delivery of 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.	Partial
Relevant members of the multidisciplinary team were able to view the patient record via a shared clinical system. Patients were offered extended access appointments and could be referred to the local pharmacy for support. The clinical records searches undertaken by the GP CQC specialist advisor (SpA) as part of the inspection showed a large number of open tasks, scans and clinical correspondence which required attention. Therefore, we were not assured that patients always received consistent and coordinated care when they moved between services.	

Helping patients to live healthier lives

Staff were 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.	Partial
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Co-ordinated care was available for patients in the last 12 months of their lives. Staff were able to refer and signpost as necessary to a number of support organisations within the locality. There were structured processes in place to enable the patient services team to appropriately care navigate patients to the most suitable clinician. During the pandemic the practice provided a local café with weighing scales and blood pressure monitoring machines to encourage patient involvement in monitoring and managing their own health. Patient education screens were in place at both sites, which communicated self-care messages and detailed support groups. As part of our inspection, the CQC SpA undertook a number of in-depth searches of the practice's clinical records system. The searches showed the regular use of a code for medicines reviews without evidence of a full review, any discussion with the patient or any documentation to support the decision made.	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
For patients who were residents in care homes, completed DNACPRs were retained at the home and were digitally available in the person's record and therefore also available to emergency organisations.	

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.

	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
On the day of inspection, the staff team demonstrated an understanding of the cultural, social and religious needs of patients. Staff were able to describe in detail the support offered to different patient groups and how they would use the clinical system to support patient needs. For example, reminders would be placed on the home screen which reflected patient preferences. This could be for an afternoon appointment, the need for an interpreter or they may wish to see a male or female clinician only. Staff spoke positively about patients and their role in supporting patients to access and provide appropriate services.	

Patient feedback	
Source	Feedback
Friends and family	The practice had received three pieces of patient feedback in June 2022. Two patients said they were likely or extremely likely to recommend the practice to their family and friends and one patient said they didn't know. When asked how they felt about how they were listened to, welcomed, treated and their overall experience, all three patients chose the 'great' option.
Observation	On the day of inspection, we saw that staff were kind and respectful to patients in person and on the telephone.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	84.6%	87.2%	89.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time	86.4%	86.7%	88.4%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)				
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	93.0%	94.5%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	73.8%	79.9%	83.0%	No statistical variation

Any additional evidence or comments

A practice action plan was in place in response to the National GP Patient Survey. Active recruitment was on-going for salaried GPs and advanced clinical practitioners.

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

Any additional evidence

The practice had undertaken patient survey exercises annually pre-pandemic and firm plans were in place to restart these.

In 2019/20 the survey showed of 143 patients 74% said they would recommend the service.

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
The team were able to access information for patients in languages other than English, plus easy read and pictorial materials.	

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	89.4%	90.5%	92.9%	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.	Yes
The practice website was being updated to reflect current support for patients and this had been discussed with the patient group. Leaflets were available for patients at the surgery and staff would send links to information via text messages.	

Carers	Narrative
Percentage and number of carers identified.	266 carers were identified, which was 2% of the patient population.
How the practice supported carers (including young carers).	Carers information was available on the website and in the practice. A staff board in the administration office detailed new or existing support groups for patients which staff could refer to during calls.
How the practice supported recently bereaved patients.	Individualised support was available for bereaved patients.

Privacy and dignity

The practice always respected 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.	Yes
Telephone calls to the practice were answered in offices which were separate from patient areas.	

Responsive

Rating: Requires Improvement

At the inspection on 17 May 2016 the provider was rated as good for providing responsive services. At this inspection on 22 and 23 June 2022 we rated the provider as requires improvement for providing responsive services. On the day of inspection, we found that patient feedback regarding the practice was mixed. One care home told us they were often unable to contact the provider by telephone and the provider had been unable to assure themselves that issues with the premises had been managed and responded to.

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
During our inspection we noted a number of issues with the premises at both sites used by the provider. Some of these required the provider to improve how they implemented and managed systems and processes for example infection, prevention and control. The provider had been unable to resolve urgent matters with the landlord of the premises used, to allow them to safely manage issues relating to some risk assessments. For example, those relating to the legionella bacteria. The staff team had completed COVID-19 psychology training, this assisted them to understand the disease and support patients. The National GP Patient Survey showed that only 51% of patients felt they had enough support from local organisations to manage their long-term conditions. The practice was recalling all patients whose reviews may have been delayed due to the pandemic. Until February 2022, weekly HERON meetings, (Hollyns Emergency Response and Resilience Update) were held to ensure staff felt fully supported and kept up to date with the latest government guidance during the COVID-19 pandemic.	

Practice Opening Times			
Day	Clayton	Time	Allerton
Opening times:			
Monday	8am-6pm		8-1pm

Tuesday	8am-6pm	8-6pm
Wednesday	8am-6pm	8-1pm
Thursday	8am-6pm	8-6pm
Friday	8am-6pm	8-1pm
Appointments available:		
Monday	8am-12pm and 1pm-6pm	8am-12pm
Tuesday	8am-12pm and 1pm-6pm	8am-12pm and 1pm-6pm
Wednesday	8am-12pm and 1pm-6pm	8am-12pm
Thursday	8am-12pm and 1pm-6pm	8am-12pm and 1pm-6pm
Friday	8am-12pm and 1pm-6pm	8am-12pm

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

- The practice team reviewed and responded to guidance during the pandemic and continued to see patients as advised. A RAG rating (red, amber, green) was allocated to clinical procedures, which enabled the patient services team to identify who could be safely seen face to face and where non-contact appointments could be utilised.
- A 'Pets as Therapy', dog was available to the practice.
- During the pandemic the practice had completed a large amount of wellbeing calls to patients including the elderly and vulnerable, signposting them to food banks, supermarkets who were offering deliveries, dog walking, befriending and other services which were available to patients locally.
- There was a medicines delivery service for housebound patients.
- The practice liaised regularly with the local voluntary and community services to discuss and manage the needs of patients with ongoing needs and complex medical issues.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability. Staff told us that when a patient did not attend a booked appointment, a review of their notes would take place to assess for any vulnerability/safeguarding concerns and they would arrange a further appointment if necessary.
- 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 and offered longer appointments to enable health checks to be completed.

Access to the service

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

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
<p>Patients could access telephone appointments, econsultation and face to face appointments as clinically necessary.</p> <p>Appointments were available in the extended access service between 6.30pm and 9.30pm on a weekday and between 10am and 2pm at weekend. These consultations were held at various hub sites around the city. Patients could be seen by a GP, physiotherapist, social prescriber, nurse or a health care assistant.</p> <p>Patients could self-refer for support to manage their mental health. The practice supported this.</p> <p>The provider had introduced a separate mobile number for patients to ring and leave a message to cancel appointments. Additionally, the team had plans to introduce a formal system for the safety netting of patients, to ensure patients who rang on consecutive days to request an appointment were seen.</p>	

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	43.5%	N/A	67.6%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	53.2%	66.7%	70.6%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	48.9%	63.9%	67.0%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the	71.7%	80.3%	81.7%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)				

Any additional evidence or comments

The practice reviewed the care offered to patients and had responded to the National GP Patient Survey. A review of rapid access appointments had been undertaken and new pathways implemented. The management of econsultation had been reviewed. The previous system of GPs assessing econsultation in an ad hoc manner had been reviewed and changed. Allocated clinicians were now given additional time to manage these queries and respond to patients.

When contacting the practice, the telephone system informed patients of their place in the queue and what types of information could be found on the website. The practice continued to respond to patient feedback.

Source	Feedback
Care homes:	<p>We spoke with the managers of three care homes supported by the practice as part of this inspection. Feedback was mixed.</p> <p>Care home one described the clinicians allocated to the home as 'lovely', and they conducted visits to the home when required. Availability of appointments was described as challenging with long queues on the telephone. The home manager told us that they often needed to chase prescriptions and results but that monthly medicines requests were reasonably well managed.</p> <p>Care home two told us that support to their residents was 'very hit and miss'. Most contact with the home was by telephone and clinicians rarely visited. We were told that when senior staff raised concerns about the residents they were not taken seriously, and requests for medicines and prescriptions were not always actioned in a timely manner. The home reported that the practice was not available by telephone some afternoons and they would be more likely to ask for a visit from the out of hours GP as this would be accommodated.</p> <p>Care home three told us the GP allocated to their home was extremely helpful, with the views of staff and residents being taken into account. The clinician was described as a great support who would conduct visits when needed. Prescriptions and medicines changes were actioned quickly.</p>
Share your experience	A patient reported they struggled to get an appointment for a child. They were then seen by a clinician who could not perform the necessary investigation. The parent also reported additional issues with obtaining a timely prescription.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	24
Number of complaints we examined.	3

Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	1

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
<p>In addition, the practice received and reviewed 21 informal complaints. This was in response to issues and concerns raised informally with the team.</p> <p>Staff told us that they knew about complaints and when learning points were identified, these were shared with the team via email. We did not see that complaints were discussed at meetings.</p> <p>The practice had sent a formal response to the Parliamentary and Health Service Ombudsman.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient complained they were not offered an appointment or pain relief after an accident but directed to the pharmacy when the day's appointments had been taken.	Patient services staff were reminded they could utilise extended access appointments to support patients.

Well-led

Rating: Requires Improvement

At the inspection on 17 May 2016 the provider was rated as good for providing well-led services. At this inspection on 22 and 23 June 2022 we rated the provider as requires improvement for providing well-led services. The provider did not consistently maintain oversight of systems and processes such as medication reviews of patients and the management of the environment.

Leadership capacity and capability

There was compassionate and inclusive leadership, but we did not see that this was consistently effective.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Throughout our inspection, we highlighted a number of areas of concern to the provider. We saw these were responded to positively, and action was taken on a number of points with immediate effect, including the reviews of patient medicines. The team had faced a number of difficult challenges relating to the availability of senior staff during the pandemic. We saw that these were managed on a daily basis, with ongoing recruitment and support from locum staff being utilised to meet patient needs when necessary. Feedback from staff was mostly positive regarding leaders at the practice. This included ongoing day to day support and support given during longer term absences. Leaders were described as responsive and available. One member of the team told us there was a lack of support for the nursing team, whilst other members of the team told us that communication was a priority in a culture where concerns were responded to and changes made. The team had not maintained oversight of systems and processes such as the medication reviews of patients. Therefore, they could not assure themselves that they had a comprehensive picture of challenges to quality and sustainability within the team.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes

Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
The provider held an annual business planning meeting. All staff were invited to reflect on the current year and discuss the forthcoming year, including what worked well, what didn't work well and business planning. Staff told us that suggestions and better ways of working were discussed and taken onboard.	

Culture

The practice had a positive culture, but this did not consistently support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
We saw evidence of a safe and inclusive team with a genuine sense of a 'no blame culture'. Staff were encouraged to report issues, concerns and incidents to enable learning and make improvements. Leaders at the practice continually supported the wellbeing of staff. We saw a commitment to supporting team welfare. This had continued during the pandemic and initiatives which were introduced included 'fish and chip' Friday and treats for the team. Patients were offered face to face meetings to discuss non-clinical concerns and issues and there was a dedicated member of the team to manage concerns and complaints. Any issues which were not resolved were escalated to the partners for discussion and next steps. Patients seated in the waiting room had fed back to the practice that some telephone consultations could be heard from this area. The practice made changes to the environment and used a second waiting area away from the consulting rooms. The concerns were also highlighted to staff	

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

Source	Feedback
Practice feedback from six staff members.	Staff reported there were good protocols and policies in place which were easily available. The provider was described as accommodating, helpful and good at listening to staff. Diversity within the team was celebrated and were told that the team were always looking for ways to improve the service. Staff enjoyed working at the practice and supported each other.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: Well-structured regular meetings ensured that staff were aware of their roles and responsibilities and informed of changes, updates and ongoing issues in a timely manner.	

Managing risks, issues and performance

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.	No
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
In relation to issues noted within the report, the provider could not evidence functioning processes to effectively manage risk in areas such as the assessment of clinical competencies for non-medical staff and the management of a number of health and safety issues.	

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.	No
Changes had been made to infection control arrangements to protect staff and patients using the service.	Partial
Staff were supported to work remotely where applicable.	Yes
<p>The wellbeing of patients had been prioritised during the pandemic and a large number of welfare calls were made to vulnerable and elderly patients. The team actively sourced organisations to support patients and made them aware of these. This included food banks, services been offered at supermarkets, dog walking, befriending and other services available locally.</p> <p>Until February 2022, weekly HERON meetings, (Hollyns Emergency Response and Resilience Update) were held to ensure staff felt fully supported and kept up to date with the latest government guidance during the COVID-19 pandemic.</p> <p>To manage access the provider had introduced a separate mobile number for patients to ring and leave a message to cancel appointments and which enabled the team to manage the number of patients who did not attend. Additionally, the team had plans to introduce a formal system for the safety netting of patients, to ensure patients who rang on consecutive days to request an appointment were seen. At the time of our inspection patients were added to the on-call rota if appointments were all taken for a review by a clinician. We were told that all patients would be reviewed on the day.</p> <p>An NHS initiative, community pharmacy referral scheme was in place. This was an electronic referral made by the practice for patients to attend the local pharmacy for an arranged consultation. The practice was able to view the outcome in the patient record.</p> <p>There was active ongoing recruitment in place, but the provider had consistently struggled to recruit GPs. They had been successful in recruiting three new nursing staff and plans were in place to deliver additional support for patients.</p> <p>The provider had registered as an accredited overseas sponsorship practice. It was hoped this supportive initiative would help them with recruitment.</p>	

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.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
<p>We did not see that outcomes from audits and assessments such as the Legionella assessment were proactively managed to ensure patient safety and wellbeing. Following our inspection, the provider responded to a number of issues noted with the timely and appropriate management of patient medicines.</p>	

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.	Partial
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
Staff understood how to keep people and information safe. However, not all staff who worked remotely were aware of the remote working policy.	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Patient participation group meetings (PPG) had taken place in October 2021 and May 2022. The group discussed issues such as staffing, access, website challenges and changes. For example, the telephone queueing system was reviewed to enable 50 calls to be connected and information regarding the length of queue to be given. Additionally, a call back facility was introduced. A number of changes had been made as a response to patient feedback. Additional nursing staff had been recruited to increase the number of face to face clinics which the provider was able to offer.	

Feedback from Patient Participation Group.

Feedback
The PPG raised the point that the practice website was hard to navigate. As a result, the team were in the process of speaking to the web developer/host to make changes to improve this.

Any additional evidence

The nursing team highlighted that they were unable to book patients in directly with a GP when they had concerns and instead had to go via the patient services team which caused unnecessary delays. In response to this, the provider ensured appointments were embargoed on the GP/ACP rota each day that only the nursing team could utilise for patients.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
A complaints policy was in place and staff told us complaints were discussed, listened and responded to and used to improve the quality of care. Written and verbal complaints were captured and there was an identified member of staff to review and manage complaints.	

Examples of continuous learning and improvement

Teaching and learning sessions were held before monthly practice learning afternoons to inform, educate and update staff. The topics discussed were chosen in consultation with the staff team
The practice supported GP trainees and had also supported two advanced clinical practitioners in their development.

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.