

Care Quality Commission

Inspection Evidence Table

Barrington Medical Centre (1-9266579272)

Inspection date: 09 June 2022

Date of data download: 08 June 2022

Overall rating: Good

Safe

Rating: Good

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

| Safeguarding | Y/N/Partial |
|--|-------------|
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Yes |
| Partners and staff were trained to appropriate levels for their role. | Yes |
| There was active and appropriate engagement in local safeguarding processes. | Yes |
| The Out of Hours service was informed of relevant safeguarding information. | Yes |
| There were systems to identify vulnerable patients on record. | Yes |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Yes |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">• During the inspection we discussed safeguarding with members of staff. It was evident from the examples provided that safeguarding concerns were taken very seriously and acted upon. The staff were able to provide examples where concerns had been raised and appropriate actions had been taken. They were also able to evidence they received support from the practice to do this.• Reception staff remained appropriately knowledgeable about safeguarding, and all staff were aware of patients who were on the safeguarding list.• We were told of good communication with social services and health visitors and a schedule of safeguarding meetings. | |

| Safeguarding | Y/N/Partial |
|--|-------------|
| <ul style="list-style-type: none"> • Staff knew who the safeguarding lead was and when to go to them for support. • We saw that safeguarding training was monitored for all staff by the practice manager and all staff had been trained to the appropriate levels including a new member of staff. • We saw that policies and procedures were available on the shared drive and were up to date. | |

| Recruitment systems | Y/N/Partial |
|---|-------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Yes |
| Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Personnel files were well organised with all paperwork easily accessible. • We reviewed four random recruitment files including the newest member of staff and found that all necessary recruitment information was appropriately obtained. There was also evidence of appropriate inductions. • We saw that each personnel file contained the necessary contractual agreements, identification documents and training records. | |

| Safety systems and records | Y/N/Partial |
|--|-------------|
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 23/5/2022 | Yes |
| There was a fire procedure. | Yes |
| Date of fire risk assessment: January and March 2021 Actions from fire risk assessment were identified and completed. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Health and safety risk assessments were completed by the practice manager. The last completed audit was dated May 2022 and included slips and trips, manual handling of paper in the practice, display screen equipment use, working at height, stress, electrical, fire and other situations associated with working in general practice. • The practice were situated in a purpose built building owned by NHS property services. Fire assessments were undertaken by the company and the practice kept records of those, such as checks on electrical equipment, fire extinguishers and other fire associated risks. | |

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

| | Y/N/Partial |
|---|-------------|
| Staff had received effective training on infection prevention and control. | Yes |
| Infection prevention and control audits were carried out. Date of last infection prevention and control audit: August 2021 and monthly audit last completed April 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"> We walked around the building on the day of inspection and found it to be clean and hygienic throughout. All staff were trained about infection prevention and control (IPC) and one of the practice nurses took the lead, undertaking audits and ensuring all staff were up to date with the most recent guidance and information. We saw that hand washing training and audit was undertaken by the IPC lead. | |

Risks to patients

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

| | Y/N/Partial |
|---|-------------|
| There was an effective approach to managing staff absences and busy periods. | Yes |
| There was an effective induction system for temporary staff tailored to their role. | Yes |
| The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures. | Yes |
| Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients. | Yes |
| There were enough staff to provide appointments and prevent staff from working excessive hours | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> We spoke with administration staff who confirmed they could cover most roles in the event of absence, other than the secretarial role. Emergency referrals were covered by the practice manager when required. However, a new member of staff was being sourced to ensure services were not interrupted by staff absence, planned or unplanned. The practice identified that the appointment system was not working well, therefore, a new way of allocating patients was agreed with a 'red, amber, green' process. Reception staff had undergone a period of training with one of the new GP partners regarding what actions to take | |

when patients called. This had proved to be positive for both staff and patients who were now more appropriately signposted when they called.

- The newest members of staff received training on how to manage risks that may arise including basic life support, suspected sepsis, infection control and safeguarding. All other staff also received regular updates.
- Patients that may be more susceptible to risk than others had alerts on their clinical record system. There was appropriate communication between staff and clinicians about high-risk patients.
- We saw that all disciplines of staff were made aware of sepsis management and we saw information of how to manage sepsis in all clinical rooms and in reception. Staff we spoke to demonstrated their knowledge and understanding about sepsis and what to do in an emergency situation.

Information to deliver safe care and treatment

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

| | Y/N/Partial |
|---|-------------|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. | Yes |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Yes |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | Yes |
| Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals. | Yes |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Yes |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | Yes |

Explanation of any answers and additional evidence:

- We were told there was a backlog of notes that required summarising. However, a temporary member of staff was being recruited the following week to ensure this backlog was dealt with. Staff we spoke with confirmed that up till that point notes had been summarised on demand when required.
- For additional safety an additional alert was placed on all un-summarised records stating “Record received via GP2GP – please check against paper records”. This was removed when summarising was completed.
- We reviewed the document management system and noted no unacceptable outstanding tasks in any of the GPs or administration staff inboxes. This demonstrated that referrals, tests results, discharge letters and changes of medicine were managed in a timely way.

Appropriate and safe use of medicines

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

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA) | 0.80 | 0.90 | 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) | 9.4% | 11.9% | 8.8% | No statistical variation |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA) | 6.31 | 5.05 | 5.29 | No statistical variation |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA) | 121.9‰ | 171.0‰ | 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) | 0.40 | 0.66 | 0.60 | No statistical variation |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA) | 4.3‰ | 5.5‰ | 6.8‰ | No statistical variation |

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

| Medicines management | Y/N/Partial |
|---|-------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Yes |
| Blank prescriptions were kept securely, and their use monitored in line with national guidance. | Yes |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Yes |

| Medicines management | Y/N/Partial |
|--|-------------|
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review. | NA |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. | Yes |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | Yes |
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. | Yes |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Yes |
| There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer. | Yes |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | 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 |
| <p>Explanation of any answers and additional evidence:</p> <p>As part of the inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor without visiting the practice. In general, the GP SpA was satisfied with the results from the searches undertaken of Barrington clinical system, particularly given the challenges of service provision during the pandemic. The following results were identified:</p> <ul style="list-style-type: none"> • Patients taking high risk medicines, such as methotrexate, (a type of medicine that helps reduce inflammation) were being appropriately monitored. • We highlighted two patients on combination medicines such as spironolactone and ACEI/ARB (medicines for heart disease) who looked like they had not been reviewed to ensure that they were aware of any risks, were on a minimal dose or had been prescribed an alternative. The practice was able to provide evidence in the way of a protocol and a completed audit showing that all patients had been reviewed and dealt with appropriately. • DNACPR care plans were in place for patients on end of life treatment and contained information specific to the wishes of the individuals involved. | |

| Medicines management | Y/N/Partial |
|--|-------------|
| <ul style="list-style-type: none"> • Medicine reviews were appropriately managed and carried out on a regular basis. • Patients taking combination medicines such as amlodipine (for blood pressure) and simvastatin (for high cholesterol) were monitored to manage any associated risks. • We reviewed patients taking medicines for hypothyroidism to assure they were being monitored appropriately. We looked at five patients and found that three of those appeared to be overdue. We highlighted those to the practice and they were able to provide explanations. The practice sent information directly following the inspection to evidence that monitoring for those patients had been reviewed and the records were updated. | |

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 |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a lead member of staff for significant incidents and all staff contributed and were involved around incident reporting. The practice demonstrated how all staff were encouraged to raise anything whether it be clinical, staff or personal related. We saw how information was collected, documented, discussed and reviewed on the practice records management system. • Staff we spoke with and those who completed questionnaires told us they felt reassured and able to raise and discuss concerns in an open environment. Each department had individual leaders and all came together formally and informally to discuss concerns. Staff spoke of a good and open culture where people talked. • Events were collected by the clinical governance lead and reviewed and discussed at monthly meetings. Events included unexpected deaths, administration errors, clinical concerns, and compliments as well. Each event was managed and reviewed with the individuals concerned and any learning was disseminated throughout the whole practice or where applicable. | |

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

| Event | Specific action taken |
|-------|-----------------------|
| | |

| | |
|--|--|
| <p>Blood Tests. A result of a blood test was received unassigned and was assigned to the son of a patient bearing same name.</p> | <p>The error was identified quickly and no medication had been prescribed. The process of patient identification had not been followed correctly. Learning identified a two times process of ID checking needed to be followed to prevent further errors. The admin team was assigned to unmatched patients rather than the GPs for essential checking processes to be in place.</p> |
| <p>Vaccine wastage. Vaccine delivery was made to reception and put in samples fridge. Nursing team were not alerted to delivery.</p> | <p>Cold chain policy was followed and vaccines were discarded as per advice from manufacturers. Reception staff trained on cold chain on induction and signage on fridge made more prominent around what to do when vaccines are delivered.</p> |

| Safety alerts | Y/N/Partial |
|---|--------------------|
| <p>There was a system for recording and acting on safety alerts.</p> | <p>Yes</p> |
| <p>Staff understood how to deal with alerts.</p> | <p>Yes</p> |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We discussed safety alerts with the practice nurse and the practice manager. Both were able to demonstrate the process for alerts received into the practice, how they were dealt with and where action was taken when required. • We saw a patient record where a patient of child bearing age taking sodium valproate was advised of any risks involved if becoming pregnant when taking this medicine. | |

Effective

Rating: Good

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

| | Y/N/Partial |
|--|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | Yes |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Yes |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | Yes |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Yes |
| Patients' treatment was regularly reviewed and updated. | Yes |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Yes |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Yes |
| The practice had prioritised care for their most clinically vulnerable patients during the pandemic | Yes |
| | |

Effective care for the practice population

| Findings |
|--|
| <ul style="list-style-type: none">• The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.• The practice nurses offered health checks, including frailty assessments, to patients over the age of 75. The health care assistant was currently being trained to do this.• Patients received a 'happy birthday' letter when they reached 70 (and currently thereafter) to invite them for flu, shingles and pneumonia vaccinations.• The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.• Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. These were currently on hold, but the health care assistant was being trained to do these and they would be re-introduced as part of the restore and recovery programme after the pandemic.• All patients with a learning disability were offered an annual health check. |

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice also had an end of life GP lead who oversaw and supported colleagues and reviewed end of life procedures within the practice.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

As part of the inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor without visiting the practice. In general, the GP SpA was satisfied with the results from the searches undertaken of Barrington Medical Practice's clinical system. The following results were identified:

- Patients were offered treatment and rescue steroids when diagnosed with asthma. However, three of the five patients we reviewed had been prescribed two or more rescue steroids and 12 or more inhalers within the last twelve months, with or without a review. We pointed those out to the practice during the inspection. Immediately following the clinical discussions, the practice undertook a further audit. They identified that some patients were incorrectly coded and rectified this. They also introduced a new standard operating protocol and disseminated that to all staff to ensure patients were invited for appropriate review.
- Patients with chronic kidney disease were monitored appropriately.
- Patients with diabetes at risk of developing or having developed retinopathy received appropriate treatment.

The practice was also able to demonstrate that:

- 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.
- The practice nurses who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Patients with newly diagnosed cardio-vascular disease were offered statins.

- Patients with suspected hypertension were offered ambulatory blood pressure monitoring at home.

| 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) | 60 | 63 | 95.2% | Met 95% WHO based target |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 54 | 55 | 98.2% | Met 95% WHO based target |
| The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 55 | 55 | 100.0% | Met 95% WHO based target |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 55 | 55 | 100.0% | Met 95% WHO based target |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 96 | 100 | 96.0% | Met 95% WHO based target |

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

| 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) | 71.8% | 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) | 69.6% | 60.3% | 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) | 72.4% | 66.8% | 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) | 38.1% | 52.3% | 55.4% | No statistical variation |

Any additional evidence or comments

- We discussed the lower than expected level of eligible patients having received a smear test with the practice nurses who were able to demonstrate that all patients were invited, at least three times, by letter and by telephone. Nurses spoke to patients who did not wish to undertake the process and advised them of the risks and benefits of the procedures. They also undertake smears opportunistically where possible, when patients came in for other things.

Monitoring care and treatment

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

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

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

- The practice was affiliated to a nearby care home and saw residents there who were registered with the practice as well as those registered with other GP practices. One of the partners at the practice identified that the system to review and assess residents at the home, was not working well for either the practice or the residents. She found that calls were being made requesting visits, multiple GPs, or on call GPs were visiting, there was no continuation of care and visits were reactive, poorly utilised and even at times unnecessary.
- The partners discussed and agreed that a weekly session could be undertaken at the home by one dedicated partner. Since then care for the residents had improved considerably, the GP walked around the home and reviewed each resident informally each week, as well as attending to any identified concerns. Multidisciplinary meetings had been introduced involving residents' families, their own GPs (if not affiliated to the practice), community nursing, tissue viability nurses and any others who cared for the residents, for example, at the end of life.

- All residents had received a complete medicine overhaul and those on a multitude of medicines for different things had been radically reduced. For example, anti-depressant medicine had been decreased in patients with dementia as they were found to be ineffective, residents on a multitude of pain medicines had been reviewed and prn paracetamol introduced. Families had been involved in meetings about their loved ones and concerns were identified early before they became too difficult to manage.
- The GP had also trained clinical and non-clinical staff at the home to identify illnesses and understand what required urgent or non-urgent attention.
- Outcomes for residents and their families had greatly improved since this intervention which continued on a weekly basis.

We found the practice also undertook regular clinical audit in other areas. For example:

- Audits were completed immediately following the inspection on any areas of concern identified by the CQC clinical searches.
- An audit of the way in which medicines were reviewed resulted in a change to the process.
- Prevalence of long term conditions: GPs reviewed areas of own interest with a view to identify patients with missing diagnosis or missing elements of care. Audit to be completed later in year to assess improvements. GPs to retain responsibility for individual registers and monitor prevalence on-going.
- Recruitment / Training & Leadership which resulted in the successful recruitment of a reception supervisor. This improved organisation and efficiency of the reception team. In addition, the practice has received approval as a training practice. Already offering in-house mentorship to medical students the practice has also been approved to accept GP trainees and the mentorship of newly qualified GPs.

Other Improvements to care or treatment included:

- HCA commenced Trainee Nursing Assistant training in September. The practice hoped this would provide better access to preventative health and give additional support to the Nursing & GP teams
- Introduction of structured medication reviews completed by the practice pharmacists. Fully supported by the GPs, the pharmacists get longer appointments to complete those.
- Additional phlebotomy clinics were introduced to assist with the safe monitoring of patients on shared care for drugs & urgent and routine blood tests for patient convenience.
- A Cancer diagnosis audit form was introduced to instigate discussion and review for patient safety and learning.
- Increased use of the FIT test for colorectal screening was introduced to include cancer safety netting process.
- An in-house physiotherapist has reduced patient waiting times and onward referrals.
- Bitesize meetings were introduced to promote peer discussion and information sharing.
- The Practice has continued to monitor diabetic patients under hospital services due to a suspension of hospital clinics throughout the pandemic.

Effective staffing

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

| | Y/N/Partial |
|--|-------------|
| Staff had the skills, knowledge and experience to deliver effective care, support and treatment. | Yes |
| The practice had a programme of learning and development. | Yes |
| Staff had protected time for learning and development. | Yes |
| There was an induction programme for new staff. | Yes |
| Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation. | Yes |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | Yes |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Training for nurses was formalised on the practice training system and senior staff trained and mentored new members of staff, specifically through immunisation and health care checks. • Leaders provided training needs analysis through the appraisal system and staff were encouraged to develop, for example the health care assistant was being trained to become a nursing assistant. • All staff were encouraged to voice their training needs and aspirations to learn new things to help the business perform better and to provide better care for patients. • Protected time was given to all staff to complete mandatory training. | |

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 |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We saw from minutes of meetings that Gold Standard Framework meetings were held alongside Macmillan nurses, district nurses, and other GPs. Patients requiring discussion were highlighted | |

using alerts within the clinical system and records were updated before, during and after discussions when required.

- We saw multiorganisational discussions were recorded on the clinical system and were audited and tracked via tasks and patient clinical notes.
- A review of records showed that personalised care and support planning was active at each stage of a patient’s treatment and care. Clinicians liaised regularly with Macmillan nurses, cardiac and respiratory nurses and community nurses to ensure that patient centred care was delivered. The practice also delivered a service to the local nursing home on a weekly basis.

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. | 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: | |
| <ul style="list-style-type: none"> • Patients who were most likely to develop long term conditions, were offered regular annual health checks including patients on the learning disabilities and mental health registers. • Other patients were contacted and signposted to appropriate services if required regarding their weight management, smoking cessation and/or alcohol consumption. • Peak flow meters were available on prescription for asthma and COPD patients so they could keep a home peak flow diary. • Blood pressure machines were offered to patients to check their blood pressure at home. • NHS health checks were not currently offered to 40-74 year olds but this was being reintroduced as part of the practice’s restore and recovery programme. | |

Consent to care and treatment

The practice was able to demonstrate that it 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 |

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"> The practice puts patients at the centre of everything they do. They try to involve them, specifically about their care. They have a quiet room where patients can sit if they feel they need to be on their own or where mothers can breast feed or look after children. Each patient has their own GPs for continuity of care but can see other GPs if they would rather, or to get a sooner appointment. The practice make sure appointments are longer for those with multiple long term conditions. If something can be sorted on the day for the patient then they will do that rather than have them wait. Parents with babies are always seen on the day if there are any concerns. | |

| Patient feedback | |
|--|--|
| Source | Feedback |
| Friends and Family in Waiting Area and also on Website | The Friends and Family test was only recently started at the practice so there was no feedback. However, in addition to the having forms to fill in at reception, the practice were looking at different ways to communicate with patients. Friends and Family tests can be split into preferred method of contact and the practice were aiming to use text messaging and email where appropriate. |

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 | 84.7% | 92.3% | 89.4% | No statistical variation |

| Indicator | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------------|
| healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021) | | | | |
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021) | 88.7% | 91.2% | 88.4% | 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 (01/01/2021 to 31/03/2021) | 96.1% | 97.2% | 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) | 85.1% | 88.3% | 83.0% | No statistical variation |

Any additional evidence or comments

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

Any additional evidence

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 |
| Explanation of any answers and additional evidence: | |

- Reception staff are aware of each patient's individual needs – try to involve them as much as possible. – combination of small practice with staff who have been retained and they know and understand the patient population.
- There are alerts on the system - Open door alerts where patients can come in any time no questions asked
- Continuity of care with the GPs

| Source | Feedback |
|---------------------------|---|
| Interviews with patients. | We spoke with three members of the patient participation group who were also patients at the practice. They were happy with the services they had received. They also felt they were able to raise their concerns and they would be listened to, even if it was not always within the power of the practice to enforce the changes they required. |

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) | 94.6% | 96.1% | 92.9% | No statistical variation |

Any additional evidence or comments

The practice was pleased with the above result. However, they aimed to achieve the local average at the next survey, taking into account areas of other improvement such as a better appointment system and more flexible usage of appointments.

| | 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 |
| Explanation of any answers and additional evidence: | |

- The majority of the patients at Barrington Medical Centre were white British. However, this meant the practice had to work harder to ensure the minority of the patients received the care and treatment that fitted with their requirements. To ensure this they had:
 - Recently implemented a new project looking at health inequalities.
 - Involved the PPG about demographics in the hope of finding out areas for improvement.
 - Used interpreters regular.
 - Various leaflets on the practice website and on site, around the practice where they could be seen without having to ask for them.
 - Introduced an accessible standard statement on outgoing letters to find out which was the patient's preferred way of communication, example, letter, telephone, email etc. - and in which language.

| Carers | Narrative |
|---|---|
| Percentage and number of carers identified. | 4% approximately 268 |
| How the practice supported carers (including young carers). | There is information for carers set up on the website All carers were contacted to ascertain if they were still carers and invited to a carers meeting with Carers Trafford, GP, reception and nursing staff to help the practice understand how carers could be better supported. |
| How the practice supported recently bereaved patients. | The families of patients who are deceased would be contacted by the main GP for the patient. The practice staff are informed so that everyone is aware. Bereavement cards are sent and people can be signposted to the bereavement services. |

Privacy and dignity

The practice respected patients' privacy and dignity.

| | Y/N/Partial |
|---|-------------|
| A private room was available if patients were distressed or wanted to discuss sensitive issues. | Yes |
| There were arrangements to ensure confidentiality at the reception desk. | Yes |

Responsive

Rating: Good

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. | Yes |
| 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 |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had introduced an accessible standard statement on outgoing letters to find out which was the patient's preferred way of communication, example, letter, telephone, email etc. - and in which language. Patients became known as unable to use the telephone or had a preference not to have telephone consultations due to mental health issues. Those patients were seen in practice face to face during the pandemic. The practice doors were never closed and patients who felt vulnerable or in crisis continued to have access to support. | |

| Practice Opening Times | |
|-------------------------|------------------|
| Day | Time |
| Opening times: | |
| Monday | 8.00am to 6.30pm |
| Tuesday | 8.00am to 6.30pm |
| Wednesday | 8.00am to 6.30pm |
| Thursday | 8.00am to 6.30pm |
| Friday | 8.00am to 6.30pm |
| Appointments available: | |
| Monday | 9am to 5.50pm |
| Tuesday | 9am to 5.50pm |
| Wednesday | 9am to 5.50pm |
| Thursday | 9am to 5.50pm |
| Friday | 9am to 5.50pm |

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

- The reception desk was split into two parts with one part being used by another GP practice. There were two receptionists manning the desk at all times. We saw patient information leaflets available and a hearing loop to assist patients who were hard of hearing. We also saw staff wearing masks and masks available for member of the public when required.
- There was a reception supervisor who assisted the team with any problems they may encounter. This was a new position created to provide stability to the receptionist staff and enhance communication with higher management.
- The practice had been working with the PPG around appointments in order to maintain access for all people, specifically those who did have internet facilities.
- The practice had listened to feedback from staff and patients and had introduced a rag rating system where appointments were rated red, amber or green. Red appointments were urgent and given priority.
- One of the partner GPs had provided specific training to all the reception staff so they were better informed about people's requirements and better able to identify when a person might need to see a GP in an emergency and when they could be signposted elsewhere. This had greatly improved the receptionists' knowledge. Reception staff had workflow sheets to follow.
- Appointments could be made by telephone and through the internet. All appointments were scheduled in the system as telephone appointments. Every person when calling was asked whether they would like a telephone appointment or a face to face appointment. If a face to face appointment was requested, it was provided.
- All calls were recorded. The telephone system in the practice enabled the practice manager to monitor telephone conversations if required, see how many calls were waiting, and apply more staff to the telephones if needed.

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>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Chronic disease was continued throughout the pandemic as much as possible (this was relevant from the QoF achievement 2021/2022 despite being suspended) Diabetic patients under the care of the hospital were reviewed by the practice as hospital services were suspended. This service has continued to offer additional support to patients and the practice's secondary care colleagues. Patients requiring British Sign Language (BSL) were seen in practice face to face. All patients were triaged however access was not restricted if it was felt a child / young person needed to be seen. The practice found that the uptake from parents was very low when offered face to face access. Childhood immunisations continued and all high risk patients were offered Covid vaccines at the same time as their childhood immunisations. | |

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) | 59.3% | N/A | 67.6% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021) | 74.7% | 79.0% | 70.6% | 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 (01/01/2021 to 31/03/2021) | 74.9% | 75.6% | 67.0% | No statistical variation |
| The percentage of respondents to the GP patient survey who were satisfied with the | 82.5% | 88.2% | 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 undertook it's own patient survey. They sent SMS messages to patients who used services across four dates in February and April 2021 asking:

How would you rate your experience at our recent Covid vaccination clinic on a scale of 1 -5?

How might we improve this service in the future?

Would you recommend our practice to your friends and family ? Yes / No

They did this to gain feedback on how the patients rated the service and to ask where they could improve.

97% of the respondents rated their experience at one of clinics as 'Very Good'

All respondents stated that they would recommend the practice to the friends and family

They received many positive comments from patients stating that they felt the clinics were efficiently delivered and with minimal waiting times

The survey was put on the practice web page for patients to view.

Telephone manner was discussed with the teams and the practice responded to patients where required.

| Source | Feedback |
|--------------------------|--|
| For example, NHS Choices | There were 19 reviews on the internet about Barrington Medical Staff with positive and negative comments. Overall they were rated 2.5 stars. |

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. | 8 |
| Number of complaints we examined. | 8 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 8 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | 0 |

Y/N/Partial

| | |
|---|-----|
| Information about how to complain was readily available. | Yes |
| There was evidence that complaints were used to drive continuous improvement. | Yes |
| Explanation of any answers and additional evidence: | |
| Complaints were discussed at an investigatory level with those involved, then discussed with teams and again at full practice meetings. The next meeting was scheduled for end of June 2022 to go over both significant events and complaints analysis. | |

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|---|--|
| Patient felt reception staff were rude and wanted information about a referral which was not offered. | An investigation showed the member of staff did what was required but in any event the patient was apologized to. Future learning within the team showed that training for reception staff was required and this was undertaken. |

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels

| | Y/N/Partial |
|--|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Yes |
| They had identified the actions necessary to address these challenges. | Yes |
| Staff reported that leaders were visible and approachable. | Yes |
| There was a leadership development programme, including a succession plan. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Succession had been discussed and considered and two new partners had been recently recruited. This was a positive step for the practice.• The health care assistant was being trained to become a nursing assistant.• The practice had considered the use of other disciplines within their team such as recruitment of an assistant nurse practitioner or another prescribing physician. | |

Vision and strategy

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

| | Y/N/Partial |
|--|-------------|
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Yes |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Yes |
| Progress against delivery of the strategy was monitored. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Since the previous inspection in March 2018 there had been changes in leadership and governance which had proved positive for the practice.• The previous practice manager had moved into a more business manager role, providing guidance and oversight around financial aspects of the practice. A new practice manager was in place and staff we spoke with confirmed this was positive.• There were two new partners in place. We spoke with one of the new partners who was passionate about the new role. They had trained reception staff who said they felt better equipped to manage their roles and communication had improved throughout. | |

Culture

The practice had a culture which drove high quality sustainable care

| | Y/N/Partial |
|---|-------------|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | Yes |
| Staff reported that they felt able to raise concerns without fear of retribution. | Yes |
| There was a strong emphasis on the safety and well-being of staff. | Yes |
| There were systems to ensure compliance with the requirements of the duty of candour. | Yes |
| When people were affected by things that went wrong, they were given an apology and informed of any resulting action. | Yes |
| The practice encouraged candour, openness and honesty. | Yes |
| The practice had access to a Freedom to Speak Up Guardian. | Yes |
| Staff had undertaken equality and diversity training. | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> Staff spoke of an open culture with good communication. They said they would raise concerns if they had any. There was a system in place to raise concerns formally and informally. | |

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

| Source | Feedback |
|----------------------|--|
| Staff questionnaires | Good place to work; Feel happy at work; Happy to raise concerns; Open culture; Managers are good to speak to; Best manager I ever had; Open door policy. |

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: | |

- New governance structures had been introduced since the previous inspection. Reception staff now had a team leader and this had improved communication channels.
- The practice manager had introduced new protocols and responsibilities for different members of staff.
- There was an open door policy and staff felt they could go to anyone for help and/or advice.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

| | Y/N/Partial |
|---|-------------|
| There were comprehensive assurance systems which were regularly reviewed and improved. | Yes |
| There were processes to manage performance. | Yes |
| There was a quality improvement programme in place. | Yes |
| There were effective arrangements for identifying, managing and mitigating risks. | Yes |
| A major incident plan was in place. | Yes |
| Staff were trained in preparation for major incidents. | Yes |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • We saw that risks and issues were well managed throughout. • There were processes in place to discuss and review significant incidents and the practice was able to demonstrate where improvements had been made following incidents. For example, there had been an incident where the emergency trolley was required by a GP after they had carried out two procedures on a patient. It was agreed following review that only one procedure should be carried out on a patient at any one time. • In another incident the emergency trolley was required and there was discussion as to whether it should be kept in a different place. After discussion and review by the whole team it was agreed that it was in a good place where everyone was able to access it without delay and it should not be moved. • We saw the major incident plan. Copies were kept both at the practice and outside the practice where it could be accessed. Staff knew where it was kept and how to access it. Staff also had access to all major telephone numbers. | |

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 |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had made appropriate changes to their infection control protocols during and following the pandemic and staff had been trained and upskilled to deal with any emergencies in that regard. • A rag rating system had been implemented to improve access for patients and all patients were given the choice of whether they wished a telephone or face to face appointment. • We spoke with members of the administration team who confirmed there was a backlog of records that require summarisation. The practice had arranged for a temporary member of staff to be employed solely to deal with that backlog. | |

Appropriate and accurate information

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

| | Y/N/Partial |
|---|-------------|
| Staff used data to monitor and improve performance. | Yes |
| Performance information was used to hold staff and management to account. | Yes |
| Staff whose responsibilities included making statutory notifications understood what this entailed. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a person responsible for monitoring the QOF and ensuring that patients were called and recalled to appointments. They were very passionate about their role and data was updated each month and reported to managers so that the information could be used to improve performance. | |

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 |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> Staff commented about how differently services were delivered in comparison to before pandemic times. They felt they had reached a point where patients were more satisfied with the ways in which appointments could be managed and how their data was handled. They felt confident that they had the training and tools available to them to deliver these different ways of working. They felt they had instilled that confidence to their patient population. | |

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 |

Feedback from Patient Participation Group.

Feedback

| |
|--|
| |
|--|

- We spoke to three members of the patient participation group. They were a small group who wished to help the practice provide good access for the whole population and also to explore health inequalities within the population.
- They agreed to work with the practice, creating patient surveys, reaching out to the population and feeding back any issues to the practice. They said the practice worked well with them and held regular meetings.

Continuous improvement and innovation

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

| | Y/N/Partial |
|--|-------------|
| There was a strong focus on continuous learning and improvement. | Yes |
| Learning was shared effectively and used to make improvements. | Yes |
| Explanation of any answers and additional evidence: | |
| <p>We saw several areas where the practice had improved itself through learning and development, particularly where improvement had been required. For example:</p> <ul style="list-style-type: none"> • One of the partners recognised that reception staff were giving urgent appointments to all patients. This highlighted a learning opportunity and all reception staff were trained by this partner about different reasons a patient may require an appointment, how to recognise urgent appointments, when to signpost patients to emergency services and when to signpost to other services, such as the nurse or the pharmacist. This had improved access for patients. • This partner also highlighted an improvement opportunity for residents at the local care home who were being seen opportunistically and sometimes unnecessarily. A weekly ward round now takes place, where all residents were regularly assessed. • There was a continuous programme of clinical audit and improvement. | |

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