

# Care Quality Commission

## Inspection Evidence Table

### Sheet Street Surgery (1-548919177)

Inspection date: 13 June 2022

Date of data download: 26 May 2022

## Overall rating: Requires improvement

At our previous inspection in April 2016 we rated the practice Good overall, however at this inspection we have rated the practice Requires improvement because we found:

- The practices' recruitment policy and procedures were not compliant with Schedule 3 of the Health and Social Care Act 2008 because we found staff employed without a valid Disclosure and Barring Service (DBS) check or risk assessment.
- Infection prevention and control measures were not compliant with UK Health and Security Agency (UKHSA) legislation because the practice did not have complete records of immunisation which placed patients and staff at risk of contracting infectious diseases.
- Systems and processes to identify risk existed, however, when risks were identified they were not always acted on.
- Premises health and safety risks were not adequately managed, mitigated or responded to in a timely manner.

## Safe

## Rating: Requires improvement

At our previous inspection in 2017 we rated the practice as Good for providing safe services. This was a focused follow up inspection in response to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 and a rating of Requires improvement and at this inspection we have rated Safe as Requires improvement because;

- The provider had not taken all reasonable steps to safeguard children and vulnerable adults from the risk of abuse. We found examples of staff who had been employed without a Disclosure and Barring Service (DBS) check or risk assessment and those staff were continuing to work at the service.
- The provider had not taken all reasonable steps to prevent the risk of patients and staff from contracting infectious diseases had been taken because the provider did not hold records of staff immunisations in line with national guidance.
- The fire safety risk assessment had not been repeated within the recommended timeframe and not all risks identified in it had been completed. The most recent fire safety assessment showed the overall risk for the premises had increased.

### Safety systems and processes

**The practice has systems, practices and processes to keep people safe and safeguarded from abuse. However, not all were effective or in line with legislation.**

| Safeguarding   | Y/N/Partial |
|--|-------------|
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff.   | Y           |
| Partners and staff were trained to appropriate levels for their role.  | Partial*    |
| There was active and appropriate engagement in local safeguarding processes.   | Y           |
| The Out of Hours service was informed of relevant safeguarding information.  | Y           |
| There were systems to identify vulnerable patients on record.  | Y           |
| Disclosure and Barring Service (DBS) checks were undertaken where required.  | N**         |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.   | Y           |
| <p>Explanation of any answers and additional evidence:</p> <p>* During our inspection we reviewed staff training records and were unable to determine the level of safeguarding training for one member of clinical staff who was patient facing because the practices' training log did not hold this information and the practice was unable to provide copies of their records of training. The member of staff was out of the country at the time of the inspection. This information was provided after the inspection and confirmed that member of staff was trained to the appropriate level.</p> <p>** During our inspection we sampled five staff recruitment records of new members of staff and four did not have a record of a Disclosure and Barring Service (DBS) check. We asked the provider to explain their process and policy for applying for and renewing DBS checks and were told this was done on a three-year cycle. These four staff had been allowed to begin working at the practice without a DBS check or a risk assessment to ensure they were suitable to have contact with children or vulnerable patients and this had not been completed at the time of the inspection. The other member of staff was a GP registrar and it was explained that their recruitment checks were completed by the higher education establishment (HEE), however, the provider was unable to provide evidence of it or that the HEE had confirmed a valid DBS existed. We saw evidence that the practice had identified the risk that recruitment records were incomplete and had recorded it on the risk register. However, the practice's systems, processes and standard operating procedures were not always reliable or appropriate to keep people safe. The practice provided a copy of the DBS after the inspection and an updated DBS policy which confirmed staff would not begin working at the practice without a DBS check and were working to complete checks of all existing staff.</p> |             |

| Recruitment systems   | Y/N/Partial |
|---|-------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).               | N*          |
| Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role. | N**         |
| Explanation of any answers and additional evidence:   |             |

\* During the inspection we reviewed the staff recruitment files for five members of staff. The practice had a GP registrar allocated to the practice and their recruitment checks had been completed by their higher education establishment. The practice had not completed DBS checks for the four other members of administrative staff. This was not compliant with Schedule 3 of the Health and Social Care Act 2008. The practice reviewed the legislation after the inspection, and we were provided an updated DBS policy and confirmation the practice was working to complete DBS checks of all staff.

\*\* Of the five recruitment files we examined none included records of immunisations against infectious diseases. We spoke with the provider and were told their current policy was to obtain proof of immunisation against Hepatitis B for clinicians but they did not have records for diphtheria, tetanus and polio (DPT), mumps measles and rubella (MMR) for any staff. This was not in line with the UK Health and Security Agency (UKHSA) guidance. The provider reviewed the UKHSA guidance after the inspection and we were sent a new immunisation policy which was in line with this guidance, and the practice assured they were working to rectify this.

| Safety systems and records  | Y/N/Partial |
|---|-------------|
| Health and safety risk assessments had been carried out and appropriate actions taken.<br>Date of last assessment: May 2022   | Y           |
| There was a fire procedure.<br>Date of fire risk assessment: 7 June 2022  | Y           |
| Actions from fire risk assessment were identified and completed.  | N           |
| <p>Explanation of any answers and additional evidence:</p> <p>At an inspection in April 2016 we found issues with the practice's health and safety procedures and policies, specifically, those relating to fire safety risks. We rated the key question of safe as requires improvement because of these and other findings relating to safe care and treatment. We carried out a follow up inspection in March 2017 where we found improvements had been made and rated the key question Good. At this inspection we found new issues with the practice's management and response to premises health and safety risks. For example:</p> <p>We reviewed a previous fire risk assessment (FRA) from 15 October 2020 which identified eight actions and scored the fire safety risk as 'trivial'. The practice did not provide evidence at the time of the inspection that all actions had been completed. Additionally, they did provide an action plan to complete them or a risk assessment to mitigate the risks.</p> <p>We also reviewed the most recent fire risk assessment from 7 June 2022 which was overdue and should have been completed in October 2021. This FRA report identified 27 actions, all of which were medium priority except one, which was low. The overall risk score had increased from 'trivial' to 'tolerable'. Three actions from the previous FRA report in October 2020 were repeated in the 7 June 2022 report, however, two actions had been partially completed. These repeated actions were:</p> <ul style="list-style-type: none"> <li>• create and fit a fire alarm zonal map beside the fire alarm panel which had not been actioned.</li> <li>• keep records of weekly fire alarm testing. This was partially actioned due to a log existing and requiring weekly testing, however the most recent check was 25 May 2022 and despite the fire policy stating testing would occur weekly, testing was done inconsistently and not in line with their own policy.</li> <li>• designate a fire marshall for each floor of the premises to ensure the premises have been fully evacuated in the event of a fire. This was partially actioned due to fire marshalls being identified,</li> </ul> |             |

however, while having completed fire safety training they had not received specific fire marshall training for this role.

Due to receiving the latest FRA on the day of the site visit, the practice was in the process of reviewing its content. We were told by the practice that it planned to contest the factual accuracy of the latest FRA.

The ground floor toilet was not accessible for wheelchair users but the toilet on the first floor was suitable and could be accessed via a lift. However, the lift had not been serviced since September 2020 and a faulty button had been identified and we were not shown evidence it had been repaired. The premises had an evacuation chair, however, it was too wide to be used on the stairs for an evacuation or to support a patient with mobility difficulties if the lift did not work. The provider explained staff consulted with patients with mobility issues in ground floor consultation rooms so all patients had access to care, however, the ground floor toilet facilities were not accessible for all patients.

## 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.   | Y           |
| Infection prevention and control audits were carried out.<br>Date of last infection prevention and control audit: 24 May 2022  | Y           |
| The practice had acted on any issues identified in infection prevention and control audits.  | Y           |
| The arrangements for managing waste and clinical specimens kept people safe.   | Y           |
| Explanation of any answers and additional evidence:<br>The practice's infection prevention and control (IPC) audit score was 90% overall. Two minor issues had been identified but these were not felt to be areas of great concern. |             |

## 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.  | Y           |
| There was an effective induction system for temporary staff tailored to their role.   | Y           |
| The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.                   | Y           |
| Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients. | Y           |

|  |   |
|--|---|
| There were enough staff to provide appointments and prevent staff from working excessive hours   | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>Reception and administration staff we spoke with were aware of symptoms which could indicate a patient was deteriorating or acutely unwell. All staff spoke confidently of what they would in a medical emergency, how they would alert colleagues that they needed help, and all knew where the emergency equipment and medicines were stored. One member of staff provided an example of a historical incident they had been involved in and explained how they had alerted colleagues to the emergency and the clinical team had responded quickly.</p> |   |

## 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.  | Y           |
| There was a system for processing information relating to new patients including the summarising of new patient notes.   | Y           |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.  | Y           |
| Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.  | Y           |
| There was a documented approach to the management of test results and this was managed in a timely manner.   | Y           |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.   | Y           |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice had a data sharing agreement with the local hospice and the out of hours (OOH) service which allowed them to see any clinical notes made by these teams when treating their patients. The practice used a separate clinical system to share information with the ambulance service and secondary care to ensure they had the information they needed to deliver care and treatment safely.</p> <p>When patients were treated by another healthcare setting, for example OOH, treatment updates were reviewed and actioned appropriately and in a timely manner.</p> |             |

## 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)   | 0.58     | 0.74        | 0.79            | Tending towards variation (positive) |
| 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)                                       | 9.8%     | 9.3%        | 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) | 4.68     | 5.35        | 5.29            | No statistical variation             |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)  | 65.9‰    | 74.4‰       | 128.2‰          | Tending towards variation (positive) |
| 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)   | 0.46     | 0.60        | 0.60            | No statistical variation             |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)   | 3.2‰     | 5.5‰        | 6.8‰            | Variation (positive)                 |

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

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

| 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.  | Y           |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.   | Y           |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.   | Y           |
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.   | Y           |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).   | Y           |
| There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.   | Y           |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.  | 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.   | Y           |
| For remote or online prescribing there were effective protocols for verifying patient identity.   | Y           |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.   | Partial*    |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.  | Y           |
| Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.   | Y           |
| <p>Explanation of any answers and additional evidence:</p> <p>*During the site visit we reviewed the emergency medicines and equipment held by the practice. Medicines were stocked to treat several medical emergencies, however, at the time of the inspection, the practice did not have Dexamethasone on the premises to treat croup in children. (Croup is an illness which affects babies' and young children's airways). The practice explained they would normally stock this medicine from August onwards when croup was more likely to occur, however, it can occur all year round and there was not a documented record of this decision or mitigation for the risk.</p> |             |



## 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.     | Y           |
| Staff knew how to identify and report concerns, safety incidents and near misses.           | Y           |
| There was a system for recording and acting on significant events.                          | Y           |
| Staff understood how to raise concerns and report incidents both internally and externally. | Y           |
| There was evidence of learning and dissemination of information.                            | Y           |
| Number of events recorded in last 12 months:  | 13          |
| Number of events that required action:  | 13          |

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

| Event  | Specific action taken  |
|--|--|
| A child was prescribed an incorrect dose and form of medication for their age.   | The pharmacy alerted the practice to their concern and a prescription clerk reviewed the prescription and discussed it with a clinician. The dose and form were changed, and a new prescription was issued. A significant event was recorded, and the matter was discussed at a clinical meeting where the choice of therapies by the physician's associate was reviewed. Options to ensure the risk of future prescribing errors were reduced and prescriptions were issued safely were also considered. The practice created a new medication protocol for the physician's associate to increase their supervision and provide them with support and guidance. |
| A patient was prescribed two medications to take at the same time on the advice of secondary care. The practice thought one medicine should be stopped after a specified period. | The practice thought one medication should be stopped after four weeks, however, the letter from secondary care who were overseeing treatment did not indicate when the medication should be stopped. The practice asked the specialist nurse to confirm whether the medication should be continued or stopped. Afterwards the practice reviewed this incident and identified they needed to improve their awareness of the medication criteria when prescribing.  |

| Safety alerts   | Y/N/Partial |
|---|-------------|
| There was a system for recording and acting on safety alerts.   | Y           |
| Staff understood how to deal with alerts.   | Y           |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice explained that they were signed up to the Medicines and Healthcare products Regulatory Agency (MHRA) alert system and received safety alerts. These were sent to the practice pharmacist to review and run searches to identify any patients affected by the alert. These were also emailed to staff and discussed at the clinical meeting and daily briefing to make sure staff were aware of any changes.</p> <p>Our GP specialist advisor ran a search on the practice clinical system to identify patients who were taking ACE/ARB medication and a potassium sparing diuretic. All these medications may affect renal function and electrolyte balance and when taken in combination these effects are magnified. They also have the potential to raise potassium levels which may cause heart arrhythmias and muscle weakness and can be fatal. The search identified 50 patients were taking this combination of medication and of these, 18 had not had the required monitoring blood tests within the last six months. The GP specialist advisor reviewed five clinical records and of these, two patients had had their monitoring tests in the required timeframe, one was overdue monitoring by one week and another by three months but both had been sent recall reminders during the inspection to get their blood tests. One patient last had their blood tested in 2020 and was at risk of harm due to raised potassium, however, they also had been contacted during the inspection to get tested.</p> |             |

## 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.  | Y           |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.  | Y           |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.  | Y           |
| We saw no evidence of discrimination when staff made care and treatment decisions.  | Y           |
| Patients' treatment was regularly reviewed and updated.   | Y           |
| There were appropriate referral pathways to make sure that patients' needs were addressed.  | Y           |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated.  | Y           |
| The practice had prioritised care for their most clinically vulnerable patients during the pandemic   | Y           |
| Explanation of any answers and additional evidence:<br>The practice kept staff up to date with current evidence-based practice through the following ways: <ul style="list-style-type: none"> <li>• regular meetings which were minuted and shared</li> <li>• when staff attended training they shared their learning with colleagues</li> <li>• National Institute for Health and Care Excellence (NICE) guidelines were available in the practice's clinical system and the referral system included template and guidelines</li> <li>• the practice held a daily briefing to disseminate key updates to staff</li> <li>• email bulletins</li> <li>• clinicians had time allocated for an afternoon break where they discussed cases and shared information.</li> </ul> |             |

### Effective care for the practice population

| Findings  |
|---|
| <ul style="list-style-type: none"> <li>• 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.</li> <li>• Health checks, including frailty assessments, were offered to patients over 75 years of age.</li> </ul> |

- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group. However, the practice also reviewed other patients who would benefit from these immunisations on a case by case basis.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. Clinicians told us how they supported patients outside of these age ranges that wanted health assessments by discussing their specific concerns and explaining the diagnostic and screening options available.
- All patients with a learning disability were offered an annual health check. The practices' learning disability register had 28 patients recorded and of those, 16 had received an annual health check in the six months preceding the inspection. The practice showed evidence that in 2021, all eligible patients had received a health check and the practice believed they would achieve the same outcome this year.
- 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 access to the local hospices' clinical notes which allowed the practice to continue monitoring their patients care and treatment and support the hospice effectively.
- The practice held a multi-disciplinary team meeting (MDT) every six weeks to discuss patients on the palliative care register and also any patients with a recent terminal diagnosis to ensure their future care needs were considered. Recent deaths were also reviewed at the meeting to learn the circumstances and consider if any more could have been done to support the patients' wishes.
- The practice employed a part-time community nurse who supported housebound patients and we also heard of examples of the nursing team making home visits to support patients with wound management when they were not eligible for the district nursing service.
- The practice policy was for all unwell children under the age of ten to be seen on the same day by a GP.
- 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 explained they supported patients who misused substances by referring them to community support programmes such as Alcoholics Anonymous (AA) and a local organisation, Resilience, which supported patients with both drug and alcohol addiction. A member of clinical staff had attended an open AA meeting as an observer to increase their awareness and spoke highly of the support offered.
- 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

The GP specialist advisor carried out searches remotely on the services' clinical system in relation to certain long-term conditions and the findings included:

- There were four patients with chronic kidney disease at stages four or five and our GP specialist advisor reviewed all the records and had no concerns about the management of these patients. Two patients had the required monitoring completed in the last 18 months, one patient was overdue monitoring but had been living abroad since the pandemic and therefore was not being managed by the practice. One patient was overdue, but the practice recalled them immediately for their monitoring.
- 25 patients with asthma had been prescribed two or more courses of rescue steroids in the last 12 months (two or more courses of rescue steroids could be indicative of poorly managed asthma). The GP specialist advisor reviewed the clinical records of five patients and their needs were well managed and the clinical assessments at the point of prescribing followed current guidance. We also found that GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- There were 42 patients with diabetic retinopathy who had a HbA1c result greater than 74mmol/l at their last monitoring appointment. (HbA1c is the average blood glucose (sugar) levels for the last two to three months and is used to give an indication of how well controlled a patients' diabetes is). If left undiagnosed and untreated diabetic retinopathy can cause blindness. The GP Specialist advisor reviewed a random sample of five records and found no concerns. Four patients were up to date with monitoring and one patient had no information recorded but they lived abroad and had not received any medication since 2021.
- We found 21 patients with hypothyroidism had not had their thyroid function test monitoring within the last 18 months. This monitoring is used to determine the severity of a patients under-or-overactive thyroid and determines the treatment to manage the symptoms. The GP specialist advisor reviewed five clinical records and found the patients had still been prescribed medication. They discussed the cases with the practice and found one patient had received their monitoring in hospital and was taking the medication safely. Of the other four patients, the practice reviewed their records during the inspection and found one patient was being treated in a hospital and the practice wrote to their consultant to ask for an outcome of their monitoring, one patient had been recalled twice before our inspection was announced but had not responded, and two patients had been recalled during our inspection. The practice told us they would review the remaining sixteen patients to ensure they were being prescribed medication safely.
- Two patients were identified by our searches as having a potential missed diagnosis of diabetes. The GP specialist advisor reviewed these patient records and had no concerns because both had been monitored appropriately. One patient had been identified as prediabetic and further investigation confirmed prediabetes, not diabetes. The other patient had been asked to repeat the blood test to determine whether they were diabetic.
- 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.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. The nursing team had been trained to complete the monitoring reviews of these patients

and worked in consultation with the GPs. The nurses ran monthly searches to identify patients due monitoring and reviews and recalled them as appropriate.

- The practice had a register for patients with serious mental illnesses and offered annual physical health checks with a healthcare assistant and a mental health review with a GP.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- 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) | 100       | 103         | 97.1%      | 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)  | 82        | 87          | 94.3%      | 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)  | 82        | 87          | 94.3%      | 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)   | 81        | 87          | 93.1%      | 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)  | 101       | 107         | 94.4%      | Met 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>

| 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) | 72.1%    | 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)   | 72.3%    | 68.0%       | 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)  | 67.1%    | 66.4%       | 66.8%           | N/A                      |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)  | 51.2%    | 49.4%       | 55.4%           | No statistical variation |

#### Any additional evidence or comments

We asked the practice about their recall process for patients eligible for cervical screening. They explained that in addition to the national recall programme, the practice administrator ran monthly searches to identify eligible patients and sent reminders to patients to book their appointment. The nursing team also had opportunistic conversations with patients to address any concerns and encourage them to book an appointment. The practice is part of a primary care network (PCN) which gave them access to a hub of services at the King Edward VII hospital in Windsor. This included cervical screening and gave patients the option of evening or weekend appointments to support the working age patient population and increased appointment choice for other patients.

During the inspection, the practice provided their unpublished, unverified data for January to March 2022. This did not provide a direct comparison because the data in the table above is from the UK Health and Security Agency (UKHSA) whereas the practice's data was from the Quality and Outcomes Framework (QoF). The practice's figures showed 70.9% of women aged between 25 and 49 years and 74% of women aged between 50 and 64 years had attended for cervical screening. The practice also provided unverified data for other practices in the locality for comparison to demonstrate the practice had achieved similar performance.



## 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.  | Y           |
| The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements. | Y           |
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.                               | Y           |

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

The practice shared details of the audits completed in the last two years and the improvements which had been achieved. For example, in 2019 the practice audited patients with a previous myocardial infarction to ensure the optimum statin dose was prescribed and taken. (Myocardial infarction is a serious medical emergency where the supply of blood to the heart is blocked, usually by a blood clot. A lack of blood supply to the heart muscle can cause serious damage and be life threatening). The results showed that in 2019, 22% of patients were taking the recommended statin and dose. The audit was repeated in April 2022 and found 33% of patient were taking the correct dose and recommended statin. To improve this outcome further, the practice had an action plan for the pharmacist to review all patients who were not taking the correct medication or dose.



## Effective staffing

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

|  | Y/N/Partial |
|--|-------------|
| Staff had the skills, knowledge and experience to deliver effective care, support and treatment.   | Y           |
| The practice had a programme of learning and development.  | Y           |
| Staff had protected time for learning and development.   | Y           |
| There was an induction programme for new staff.  | Y           |
| 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.   | Y           |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.  | Y***        |
| <p>Explanation of any answers and additional evidence:</p> <p>*The practice explained that they did not have a standard induction programme for new staff but instead tailored the induction training to support the individual needs of each staff member. The practice confirmed that new staff would not begin working independently without completing mandatory training required by the practice and having been mentored and supported to be competent in the role.</p> <p>**Staff had access to formal coaching and mentoring through training inputs at clinical meetings, line management support and we saw there was an open-door culture at the practice. Staff we spoke with told us how they felt comfortable to approach anyone for advice or guidance and were confident they would be given the time and support needed to develop or resolve any concerns that were outside their experience or knowledge. The practice operated an annual appraisal schedule and we saw staff had received appraisals, however, the nursing staff appraisals had not been completed in the last year. We saw evidence that the provider had included this on the practice risk register and planned to prioritise appraisals for this staff group this year.</p> <p>***We were shown evidence of a medication requests protocol for the Physicians Associate (PA) which was created in response to a medication error. The protocol was created to ensure prescribing was done safely to ensure patient safety and reduce the risk of future prescribing errors. The policy required the PA to review the patient, create a medication plan and then review the case with a prescriber who either agreed the plan or amended it and then took responsibility for issuing the prescription. The practice also had a supervision policy with dedicated clinicians for trainee GPs, pharmacists and the PA.</p> |             |

## 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.   | Y           |
| Patients received consistent, coordinated, person-centred care when they moved between services.  | Y           |
| Explanation of any answers and additional evidence:<br><br>We spoke with the practice safeguarding lead and found the practice held a monthly meeting with the health visiting team to discuss cases on the child protection register and any other patients clinicians were concerned about. Before the COVID-19 pandemic, the meeting was face to face, however it had changed to a video conference and we were told this had worked effectively and the reduction in time spent travelling to the meeting gave clinicians more time for patients. |             |

## Helping patients to live healthier lives

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

|  | Y/N/Partial |
|--|-------------|
| The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.  | Y           |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health.  | Y           |
| Patients had access to appropriate health assessments and checks.  | Y           |
| Staff discussed changes to care or treatment with patients and their carers as necessary.  | Y           |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.   | Y           |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice website included information about community services which could help patients improve their health. For example, smoking cessation, drug and alcohol abuse and children's health advice.</p> <p>The practice also had access to local services to support patients to manage their health and these included a virtual community frailty ward which supported patients who lived at home with moderate or severe frailty, dieticians, occupational therapists and physiotherapists. In addition to the local services available, the PA also supported patients with weight management advice and guidance.</p> |             |

## 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.   | Y           |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.   | Y           |
| Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.   | Y           |
| <p>Explanation of any answers and additional evidence:</p> <p>During the inspection we reviewed staff training records and found all staff were up to date with mental capacity training. We also interviewed staff and confirmed their understanding of the legislation and guidance and discussed the conversations they would have with patients to support them to make decisions and assure themselves that the patient had the mental capacity to understand and make decisions.</p> |             |

## Responsive

## Rating: Good

*The data and evidence we reviewed in relation to the responsive key question as part of this inspection did not suggest we needed to review the rating for responsive at this time. Responsive remains rated as Good.*

### 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   | Y           |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)   | Y           |
| Patients were able to make appointments in a way which met their needs   | Y           |
| There were systems in place to support patients who face communication barriers to access treatment  | Y           |
| Patients with most urgent needs had their care and treatment prioritised   | Y           |
| There was information available for patients to support them to understand how to access services (including on websites and telephone messages)   | Y           |
| Explanation of any answers and additional evidence:<br><br>The practice offered a mixture of face to face and remote consultations and explained that patients could choose the type of appointment they wanted.<br><br>The appointment structure operated via a mixture of same day and pre-bookable appointments which could be booked via the telephone, walk-in or online.<br><br>Same-day appointments were released twice daily at 8am and 1.30pm and the practice aimed to offer pre-bookable appointments to patients between four and six weeks in advance. At the time of the inspection the practice was offering appointments six weeks ahead and we reviewed when the next pre-bookable appointments were available, and these were as follows: <ul style="list-style-type: none"><li>• female GP – four days after inspection</li><li>• male GP – eight days after inspection</li><li>• nursing team – three days after inspection</li></ul> |             |

The practice is part of a PCN which gave them access to a hub of services at King Edward VII hospital, Windsor. This had been created to improve access for patients by offering extended hours appointments in the evenings and at the weekend. Patients could access GP, nurse and paramedic appointments at the hub. The practice was allocated a quota of appointments daily which were exclusively for their use but there were also general appointments for all PCN member practices which could be used as well.

The practice allowed patients to submit enquiries via the website and these were monitored by the administration staff. To ensure patients knew urgent enquiries should not be submitted this way, the practice asked patients to sign an acknowledgement confirming they understood, and that the response may take two working days. The practice told us they had audited the enquiries and seen high usage from patients aged between 50 and 59 years of age, and this had resulted in reduced demand on the telephone. However, we were not shown evidence of this impact.

The practice had installed a new telephone system six weeks before the inspection and this allowed them to monitor the number of active calls, the number of calls waiting, and the length of time patients had been queuing to speak with the practice. While on site we reviewed the system and there were three calls waiting and two in progress and the longest waiting time was three minutes.

We spoke with staff about how they would prioritise patients with urgent needs and were told by reception staff that if they had any concerns or a patient was asking for urgent access to care or treatment, they would speak to a supervisor or a clinician for advice. We also spoke with clinicians who gave several examples of how they had seen walk-in patients and done home visits to ensure patients who needed urgent care received it in a timely manner. One example provided happened during the site visit where a clinician had seen a patient in the reception area who needed advice and they had invited them to have a consultation immediately to ensure they received the care they needed.

## Well-led

## Rating: Requires Improvement

At our inspection in April 2016 we rated the practice as Good for providing well-led services. At this inspection we have rated well-led as Requires improvement because:

- Systems to support governance and management existed but were not always effective because they had not identified non-compliance with best practice guidance and legislation to ensure safe care and treatment was provided to patients.
- Systems and processes were in place to identify risks, however, in some cases there was no documented risk assessment or, action had not been taken in response and we were not assured that services provided to patients were safe.

### Leadership capacity and capability

**There was compassionate and inclusive leadership at all levels. However, leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care in all areas.**

|   | Y/N/Partial |
|---|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability.   | Y*          |
| They had identified the actions necessary to address these challenges.  | Y           |
| Staff reported that leaders were visible and approachable.  | Y           |
| There was a leadership development programme, including a succession plan.  | Y**         |
| Explanation of any answers and additional evidence:<br><br>*We found that staff had the skills, knowledge and competence to provide effective clinical care to patients and this was supported by the findings of the remote searches completed by our GP specialist advisor. However, our findings in relation to the practice's recruitment processes, management of health and safety risks and overall record keeping did not give us complete assurance that the leadership and management were aware of, or placed sufficient priority on, the requirements in all areas of governance and management to ensure high quality care and safe services.<br><br>***The practice was aware of potential retirements soon and the career plans of their staff and had a succession plan to adapt to these changes. The practice was a training practice and had successfully recruited a GP Registrar, a qualified doctor in training to become a salaried GP and was keen to continue training staff as a method of identifying and recruiting talented staff. |             |

## Vision and strategy

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

|   | Y/N/Partial |
|---|-------------|
| The vision, values and strategy were developed in collaboration with staff, patients and external partners.   | Y           |
| Staff knew and understood the vision, values and strategy and their role in achieving them.   | Y           |
| Progress against delivery of the strategy was monitored.  | Y           |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice had a clear vision and strategy and had identified priorities which included working in partnership with patients, their families and carers, involving them in decision making about their treatment and care and an ethos of “no decision about me without me”.</p> <p>We explored how these were developed and they were created by the management and leadership at an away day and then the shared with the staff for development and agreed. The practice monitored progress against the strategy via patient feedback surveys and complaints.</p> |             |

## Culture

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

|  | Y/N/Partial |
|--|-------------|
| There were arrangements to deal with any behaviour inconsistent with the vision and values.  | Y           |
| Staff reported that they felt able to raise concerns without fear of retribution.  | Y           |
| There was a strong emphasis on the safety and well-being of staff.   | Y           |
| There were systems to ensure compliance with the requirements of the duty of candour.  | Y           |
| When people were affected by things that went wrong, they were given an apology and informed of any resulting action.  | Y           |
| The practice encouraged candour, openness and honesty.   | Y           |
| The practice had access to a Freedom to Speak Up Guardian.   | Y           |
| Staff had undertaken equality and diversity training.  | Y           |
| Explanation of any answers and additional evidence:<br>We spoke with several staff during the inspection who all told us leaders and management were visible, approachable and compassionate. They spoke of the effective support they received and the collaborative culture at the practice and shared examples to demonstrate how patient care always came first. Staff were also confident that if they had concerns, they could approach anyone to discuss them and would be supported appropriately. |             |

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

| Source              | Feedback   |
|---------------------|--|
| Clinical team       | This member of staff told us they had previously changed jobs quite frequently and wouldn't work at the practice if they didn't enjoy it. They told us they really liked coming to work.   |
| Administration team | This member of staff told us how supportive management had been when the new phone system was installed. Despite not knowing any more about the system than them, they had made all staff feel they were learning together and had always been available to help others.                       |
| Management team     | This member of staff told us they believed every person has different needs and it was important for them that staff can do their work in the way that works best for them.  |
| Partners            | This member of staff told us how much they valued and trusted their team and felt confident to share responsibilities with colleagues. They also told us how much they enjoyed working at the practice and how important it was for them to continue helping patients to live healthier lives. |



## Governance arrangements

**There were clear responsibilities, roles and systems of accountability however, they did not support good governance and management.**

|   | Y/N/Partial |
|---|-------------|
| There were governance structures and systems which were regularly reviewed.   | P*          |
| Staff were clear about their roles and responsibilities.  | Y           |
| There were appropriate governance arrangements with third parties.  | Y           |
| <p>Explanation of any answers and additional evidence:</p> <p>*The practice had governance systems and processes; however, the arrangements were not always appropriate or effective and when decisions were made, they were not always documented, risk assessed or acted on. For example, we found:</p> <ul style="list-style-type: none"> <li>• There was a system and process for applying for and renewing DBS checks, however it was not appropriate because we found staff had commenced employment without valid DBS checks or appropriate risk assessments in place.</li> <li>• The practice had a policy for monitoring and recording the immunisation status of clinical staff against infectious disease, however, the system was not appropriate or effective because it only monitored and recorded Hepatitis B for clinical staff which was not in line with UKHSA guidance.</li> <li>• Management of health and safety risks to the premises was identified as an issue at our April 2016 inspection and the provider demonstrated improvement at a follow up inspection in March 2017. However, at this inspection we found oversight of health and safety risks was inconsistent and not always operated effectively because the fire risk assessment had not been reviewed within the recommended time period. The overall risk and the number of associated actions to mitigate the risk had increased. This did not give us assurance that the provider had understood the severity of the risk or prioritised it accordingly.</li> <li>• Emergency medicines were stored, and stock levels and expiry dates were routinely monitored, however, the decision not to stock Dexamethasone was not recorded and there was no risk assessment to mitigate the risk to service users.</li> <li>• The practice had a system to monitor whether staff were up to date with mandatory training required by the practice, however, the system to provide assurance for staff who had completed training in another healthcare setting was not effective because the provider did not have copies of the training records.</li> <li>• The practice had not identified that their certificate of registration was not accurate due to changes in the partnership. However, when we identified this to the practice, they immediately took action to find out why their applications to update the registration had been rejected and what changes were necessary changes to make the certificate accurate.</li> </ul> |             |

## 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.  | Partial*    |
| There were processes to manage performance.   | Y           |
| There was a quality improvement programme in place.   | Y           |
| There were effective arrangements for identifying, managing and mitigating risks.   | N*          |
| A major incident plan was in place.   | Y           |
| Staff were trained in preparation for major incidents.  | Y           |
| When considering service developments or changes, the impact on quality and sustainability was assessed.  | Y           |
| <p>Explanation of any answers and additional evidence:</p> <p>* The practice had a risk register to record identified issues, however, the provider did not have effective oversight and mitigation arrangements in all cases because some risks had not been identified and for those that had, not all had a documented risk assessment or action plan to mitigate them. For example:</p> <ul style="list-style-type: none"> <li>• Training records for a member of staff were held by another employer. The provider had received assurance training was completed but did not have copies of completion and therefore could not be assured the member of staff was competent and qualified to carry out their role.</li> <li>• Recruitment processes were not compliant with Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because we found four new members of administrative staff had not had a DBS check or risk assessment in place before commencing their employment and one GP Registrar had told the practice they had, but the provider did not have a copy to assure themselves there were no concerns. There was no documented risk assessment to manage or mitigate the risk of these staff having contact with children and vulnerable adults.</li> <li>• The provider did not hold immunisation records against infectious diseases for staff in line with UKHSA guidance.</li> <li>• Oversight arrangements for fire safety risks were not effective because three actions identified in an October 2020 FRA were also included in the more recent FRA completed in June 2022 and received during the inspection. Additionally, the overall risk and number of actions had increased from trivial to tolerable.</li> <li>• The practice had chosen not to stock Dexamethasone in their emergency medicines and told us the reason for this was because it was unlikely to be required all year round due to the condition it was required to treat (croup in children). However, there was no documented risk assessment to record this decision and what mitigation was in place should an emergency requiring this medication arise.</li> </ul> |             |

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

|  | Y/N/Partial |
|--|-------------|
| The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.  | Y           |
| The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.  | Y           |
| There were systems in place to identify and manage patients who needed a face-to-face appointment.   | Y           |
| The practice actively monitored the quality of access and made improvements in response to findings.   | Y           |
| There were recovery plans in place to manage backlogs of activity and delays to treatment.   | Y           |
| Changes had been made to infection control arrangements to protect staff and patients using the service.   | Y           |
| Staff were supported to work remotely where applicable.  | Y           |
| <p>Explanation of any answers and additional evidence:</p> <p>To improve access, the practice had recently installed a new telephone system which allowed them to monitor call volumes, calls waiting and the waiting time so they could respond to. To help reduce the call volume the practice had a system where patients could submit non urgent enquiries which would be reviewed and responded to within two working days.</p> <p>The practice had considered the needs of vulnerable patients to ensure they had access to primary care. Homeless patients were seen on the same day and could use the practice address or the local church to register and refugees could register without identification.</p> |             |

## 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.   | Y           |
| Performance information was used to hold staff and management to account.                           | Y           |
| Staff whose responsibilities included making statutory notifications understood what this entailed. | Y           |

## Governance and oversight of remote services

|   | Y/N/Partial |
|---|-------------|
| The practice used digital services securely and effectively and conformed to relevant digital and information security standards.   | Y           |
| The provider was registered as a data controller with the Information Commissioner's Office.  | Y           |
| Patient records were held in line with guidance and requirements.   | Y           |
| Patients were informed and consent obtained if interactions were recorded.  | Y           |
| The practice ensured patients were informed how their records were stored and managed.  | Y           |
| Patients were made aware of the information sharing protocol before online services were delivered.   | Y           |
| The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.  | Y           |
| Online consultations took place in appropriate environments to ensure confidentiality.  | Y           |
| The practice advised patients on how to protect their online information.   | Y           |
| Explanation of any answers and additional evidence:<br><br>We reviewed the practice's information governance policy which provided staff with clear expectations and guidance on how to deliver remote services effectively and securely, and of their obligations to protect confidential patient information. |             |

## Engagement with patients, the public, staff and external partners

**The practice involved staff and external partners to sustain high quality and sustainable care and planned to increase involvement of the public.**

|  | Y/N/Partial |
|--|-------------|
| Patient views were acted on to improve services and culture.   | Y           |
| The practice had an active Patient Participation Group.  | N*          |
| Staff views were reflected in the planning and delivery of services.   | Y           |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.   | Y           |
| Explanation of any answers and additional evidence:<br>*The practice told us that engagement with the patient participation group (PPG) had been reducing prior to the COVID-19 pandemic, however, during the pandemic, the group stopped meeting. A patient had contacted the practice and shown interest in resurrecting the PPG and the practice had given responsibility for developing the PPG to a salaried GP. The practice showed us evidence of their vision to create a PPG with sub-groups, for example, patients with long-term conditions and parents. The aim was to meet virtually and face-to-face, however this had not yet been started. |             |

Feedback from Patient Participation Group.

| Feedback  |
|---|
| We tried to speak with the patient representative but were unable to throughout the duration of the inspection. |

## Continuous improvement and innovation

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

|   | Y/N/Partial |
|---|-------------|
| There was a strong focus on continuous learning and improvement.  | Y           |
| Learning was shared effectively and used to make improvements.  | Y           |
| Explanation of any answers and additional evidence:<br>During the inspection we were informed the practice lead for minor surgery had changed. We interviewed them and they spoke passionately about how they wanted the best outcomes for patients and recognised that the practice had employed a member of staff who had recent experience as a surgeon in secondary care. The previous lead had felt it was more appropriate for the new member of staff to take on this role to ensure patient outcomes were as good as they could be. |             |

## Examples of continuous learning and improvement

We spoke with a member of staff who demonstrated their desire to continue learning by explaining how they wanted to understand the support services for patients and had done so by attending AA as an observer.

We learned the practice had employed a clinician who had previously worked at a hospice and they were the palliative and end of life care lead to ensure these patients got the most appropriate support in a timely manner.

We spoke with the safeguarding lead and they told us how during the COVID-19 pandemic the meetings with health visitors had become virtual video conferences and how they felt this had no impact on the quality of the meeting and had improved the quality of patient care because they could spend more time focusing on patients rather than travelling.

## 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)     | $\leq -3$              |
| Variation (positive)                 | $> -3$ and $\leq -2$   |
| Tending towards variation (positive) | $> -2$ and $\leq -1.5$ |
| No statistical variation             | $< 1.5$ and $> -1.5$   |
| Tending towards variation (negative) | $\geq 1.5$ and $< 2$   |
| Variation (negative)                 | $\geq 2$ and $< 3$     |
| Significant variation (negative)     | $\geq 3$               |

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

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

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

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

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

## Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- $\%$  = per thousand.