

Care Quality Commission

Inspection Evidence Table

The Caxton Surgery

Inspection date: 28 November 2022

Date of data download: 08 November 2022

Overall rating: Requires Improvement

At our previous inspection on 8 September 2016, we rated the provider as good overall. At this inspection in November 2022, we rated the provider as requires improvement overall because improvements were required in relation to the safe management and monitoring of long-term conditions and high-risk medicines.

Safe

Rating: Requires Improvement

At our previous inspection in September 2016, we rated the provider as good for providing safe care and treatment. At this inspection in November 2022, we rated the provider as requires improvement because:

- Not all staff had received the appropriate level of safeguarding training required for their role. Whilst patients with safeguarding concerns including children and their siblings were coded on the clinical system, there were no codes or alerts routinely placed on the records of adult household members of children with safeguarding concerns.
- The practice did not have effective systems in place for some processes relating to the safe management of medicines and reviews.
- Good practice guidance regarding the appropriate authorisation of Patient Group Directives to administer medicines had not been followed.
- There was no process for ongoing management of historical safety alerts.
- An effective system was not in place for the management of administrative tasks.

Safety systems and processes

The practice did not always have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes

Safeguarding	Y/N/Partial
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.	Partial
Explanation of any answers and additional evidence:	
<p>The practice had lead practitioners for adult and child safeguarding as well as a deputy child safeguarding lead and a safeguarding administration lead. Staff were aware of who the safeguarding leads were in the practice.</p> <p>The practice had adult and child safeguarding policies which were seen during the inspection. However, not all staff had received the appropriate level of safeguarding training required for their role. We saw evidence that safeguarding cases were discussed on an ad-hoc basis at weekly clinical meetings which were attended by the GPs, practice nurses and pharmacists. There were no regular formal specific safeguarding meetings with other health and social care professionals such as health visitors or adult social care professionals. The practice told us that a regular complex patient meeting was in the process of being established to provide a forum for discussing adult safeguarding cases regularly.</p> <p>Regular searches were run to identify children who had missed immunisations and the families concerned were followed up by phone or letter. Systems were also in place to follow up patients who had not attended hospital appointments.</p> <p>Whilst patients with safeguarding concerns including children and their siblings were coded on the clinical system, there were no codes or alerts on the records of adult household members in four of the five records of children with safeguarding concerns we checked.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
Explanation of any answers and additional evidence:	
<p>We looked at the files of five staff members who had recently been recruited. We saw recruitment check had been carried out. On the day of the inspection, full employment history was missing from two of the five files checked. This was discussed with the practice manager and following the inspection, we received copies of their curriculum vitae. We saw that there had been a gap in employment for one member of staff, no satisfactory written explanation was available for this gap in employment.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 08 March 2022	Yes*
There was a fire procedure.	Yes
Date of fire risk assessment: 29 January 2020	Yes*

Actions from fire risk assessment were identified and completed.	
Explanation of any answers and additional evidence:	
Examples of the various health and safety checks and risk assessments undertaken included:	
<ul style="list-style-type: none"> • Portable appliance testing: 03 May 2022 • Maintenance of fire alarm and detection system/portable fire extinguishers/emergency lighting system October 2022 • Shropshire Fire and Rescue service visit had been carried out on the 22 August 2022 	
<p>* The fire risk assessment of 29 January 2020 identified that the five-year periodic fixed electrical hard wiring safety checks had not been undertaken. The action plan stipulated a date of 29 April 2020 for this to be completed as the last check was undertaken in the early 1990s. The subsequent Health and Safety Risk assessment of 08 March 2022 also identified that the fixed electrical five-year periodic wiring safety checks had not been undertaken. No electrical safety hardwiring certificate was available at time of this visit; however, a recent safety check had been undertaken on 11 November 2022 and a copy was forwarded to us following the inspection.</p>	

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: 02 November 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:	
<p>Staff had access to an Infection Prevention and Control (IPC) policy and the practice had a designated IPC lead. Training records showed staff had received essential IPC training.</p> <p>An external cleaning company were responsible for cleaning the practice.</p> <p>Staff confirmed they had adequate supplies of personal protective equipment. Enhanced IPC measures as a result of the Covid-19 pandemic continued to be implemented, including the requirement for patients and all staff to wear face coverings and to social distance where possible to help protect against cross contamination.</p>	

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

Information to deliver safe care and treatment

Staff had/most of 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. ¹	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.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence:	
<p>The practice had a process for managing two week wait referrals. Patients were given a hard copy of their referral and a task was sent to the secretaries to submit the referral electronically. The secretaries followed up the patient 2 weeks later to make sure they had been seen in secondary care or had received an appointment. A review of patients' records showed that those referrals we reviewed had been made promptly and in accordance with best practice suspected cancer guidance. Referral templates were used and contained appropriate information. The patients had been reviewed by secondary care within two weeks following referrals.</p> <p>The practice had a process for managing pathology results, which included a review by the requesting clinician on the day they were received. Arrangements were in place if the requesting clinician was not working. There was a dedicated member of staff who reviewed cervical screening results.</p> <p>We reviewed the pathology inbox on the clinical system and found 184 results were waiting to be processed. Most of these results had been received within the 48 hours prior to the inspection. However, there were four results from 2020 to 2021, four results from August 2022 and 16 cervical smears from 19 October 2022 to 22 November 2022 waiting to be processed. The practice was asked why these results had not been processed within one to two days. On the day of the visit, the practice informed us that they</p>	

had located these and had actioned them. They further explained that appropriate action had already been taken at the time and that they were sitting within the inboxes or staff that did not usually receive results. The practice had since reviewed the computer settings to ensure key staff had 'global view' so that they could identify any unusual or unfiled results going forward.

The practice explained that the cervical smear results had since been checked and filed.

The practice used patient and admin note tasks to communicate information, for example to arrange referrals. There were a large number of outstanding tasks (24,187) with patient notes dating back to at least February 2019. The practice kept some of these tasks as an audit trail of actions taken. The practice was asked to explain why there was such a large number of outstanding tasks which could make it difficult to identify tasks that had not been actioned. On the day of the inspection, we were informed that upon review, the tasks related to access to records and confidentiality statements. By the end of the inspection visit, the number of outstanding tasks had been greatly reduced.

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.91	0.84	0.82	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). (01/07/2021 to 30/06/2022) (NHSBSA)	6.9%	7.4%	8.5%	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 (01/01/2022 to 30/06/2022) (NHSBSA)	5.60	5.20	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	130.0‰	126.9‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group	0.50	0.56	0.59	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) <small>(NHSBSA)</small>				
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	7.2‰	6.7‰	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).	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.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. ¹	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. ²	Partial
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.	NA
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

Medicines management	Y/N/Partial
Explanation of any answers and additional evidence, including from clinical searches.	
<p>We looked at five patient group directions (PGDs) and found that all of them had been signed by the appropriate staff but had been completed incorrectly. None of the PGDs we looked at had blank areas crossed through to prevent the addition of more staff names after the authorising manager had signed off the PGD. We saw that although most nurses' signatures had been added prior to the authorising manager, some had been added afterwards. This meant that those nurses had not therefore been appropriately authorised by the authorising manager to use the PGDs to administer medicines.</p> <p>The CQC searches and subsequent records review performed showed that the practice had a process in place for checking and monitoring some but not all of the high risk medication. For example:</p> <ul style="list-style-type: none"> • The 3 patients reviewed who had been prescribed a medicine used to treat inflammatory conditions like rheumatoid arthritis, were all up to date with their monitoring checks. However, these patients did not have the day of the week on which the patient should take the medication recorded on their prescription as per a Medicines and Healthcare products Regulatory Agency (MHRA) drug safety update issued in September 2020. • One patient who was prescribed a medicine to treat inflammatory conditions like rheumatoid arthritis, was overdue monitoring checks. However, evidence was seen that the practice had contacted this patient to arrange monitoring. • Twenty-seven out of 79 patients who had been prescribed a medicine to treat heart failure and high blood pressure had potentially not had kidney function checks in the last 6 months. Upon review of patients' records, we found that 4 out of 5 patients were overdue their monitoring. • One hundred and forty out of 1407 patients who had been prescribed another medicine used to treat heart failure and high blood pressure had potentially not had the required monitoring. The practice was aware that some of the monitoring was overdue as a result of the COVID-19 pandemic and was working to catch-up by prioritising patients at greatest risk. 	

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:	4
Number of events that required action:	4
Explanation of any answers and additional evidence:	
<p>The practice had a process for raising and investigating incidents/significant events. Staff had access to a policy for significant events which was seen during the inspection. Staff were encouraged to report incidents to the Practice Manager who would investigate what happened and identify any learning. Significant Event record forms to record incidents and the learning from them were available on the</p>	

practice's intranet.

The practice had a log to record significant events/incidents and their learning outcomes. Significant events and the learning from them were discussed at practice meetings.

Example of significant event recorded and actions by the practice.

Event	Specific action taken
A GP identified that 1 of the medicines about to be used for minor operations was found to be out of date.	The practice identified that the medicine did not appear on the list of medicines to be checked. The list had since been amended to include this medicine.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Partial
Staff understood how to deal with alerts.	Yes

Explanation of any answers and additional evidence:

The practice had a process for managing new safety alerts records. Safety alerts were reviewed, and any action required discussed with a GP. Searches were ran if required to identify any patients at risk and so that appropriate action could be taken in response to the alert.

The records reviewed showed that:

- The practice had acted on an alert which advised that patients prescribed a type of diabetes medicine had been made aware of the associated risks.
- We saw evidence of good practice in relation to the management of a patient of childbearing age, who had been prescribed a type of medicine to treat epilepsy. Appropriate documentation was in place ensuring the patient was fully aware of the associated risks.
- However, 33 patients had been identified as potentially being co-prescribed a combination of medicines that when prescribed together could reduce the effectiveness of 1 of the medicines (an antiplatelet). We reviewed 5 of these patients and found that all 5 patients continued to be prescribed this combination. The practice told us that although this alert would have been acted upon at the time, there was no process in place for identifying new patients affected by historical safety alerts other than at medication reviews or during medicines reconciliation. The practice was planning to improve their processes to ensure patients affected by historical safety alerts were identified.

Effective

Rating: Requires Improvement

At our previous inspection in September 2016, we rated the provider as good for providing effective services. At this inspection in November 2022, we rated the provider as requires improvement because:

- There was no formal monitoring of the non-medical prescribers.
- Some patients were overdue long-term condition reviews and there was not a robust recall system in place to call patients in for repeat monitoring checks when they were requested by a clinician.
- Clinicians were not always working in line with best practice guidance in relation to asthma and diabetes.

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

Patients' needs were assessed, but care and treatment was not always 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.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated. ³	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 prioritised care for their most clinically vulnerable patients.	Yes
Explanation of any answers and additional evidence:	
Weekly clinical meetings were held where new guidance (including prescribing guidance) was discussed. Guidance was also disseminated via the practice's intranet and during meetings held during protected	

learning time.

Evidence was seen during the remote records review of clinicians following best practice guidance for example NICE suspected cancer guidance. However, in some areas NICE guidance was not always being followed for example on diagnosing diabetes and managing asthma exacerbations with oral steroids.

Evidence was seen during the records review of patients being given appropriate safety netting advice if their condition deteriorated.

Reception staff notified a GP if a patient presented with symptoms of a serious illness.

Effective care for the practice population

Findings

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

The Nurse Practitioners led on long-term condition management. The administration team ran searches to identify patients with long-term conditions who were due a review and manage the recall process. The practice told us that the COVID-19 pandemic had meant that some patients were overdue their long-term condition reviews. The practice was in the process of working through the backlog of those reviews to catch up. We were also told that a Primary Care Network (PCN) Pharmacist was going to be working at the practice to do asthma reviews starting with those patients at highest risk for example, high users of reliever inhalers.

The long-term condition searches showed:

- Six out of 47 patients (13%) who had been diagnosed with chronic kidney disease stage four or five,

had not had blood pressure and kidney function monitoring in the past 9 months. We reviewed the records of 5 patients. One patient was overdue kidney function monitoring and was also overdue a diabetes review and a diabetes monitoring blood test. The practice confirmed on the day of the visit, that an appointment had been arranged for this patient 2 days post our inspection date. The other patients were all being monitored appropriately in secondary care.

- Seventy-six percent of patients with asthma were identified as having had 2 or more courses of oral steroids for asthma exacerbations in the last 12 months. We reviewed the records of 5 patients. All 5 patients had not been followed up within 48 hours after their course of steroids to check if they had improved as per best practice guidance. Two patients were overdue their asthma reviews, which were last done in 2020. One patient needed to be issued with a steroid emergency card as they had had more than 3 steroid rescue packs in the last 12 months. Evidence was seen of other patients being given steroid emergency cards as per a national patient safety alert. Evidence was seen of the practice agreeing asthma management plans with patients. The practice confirmed that the Nurse Practitioners were providing written personalised asthma action plans to patients.
- Twenty-five of 509 patients (5%) with hypothyroidism were identified as being overdue thyroid function checks. We reviewed the records of 5 patients. Two patients had been advised to have repeat blood tests a few months after a dose change, but this had not been done. The practice said the usual practice to recall patients was to move the patient's medication review on for a few months to ensure a clinician reviewed monitoring before the next prescription was issued. However, some patients were overdue medication reviews and monitoring and were still being issued with medication. Therefore the practice did not have, an effective recall system in place to ensure patients had the required monitoring checks and reduce the risks of over or under treatment.
- Sixty-five patients were identified as having poorly controlled diabetes and diabetic retinopathy. We reviewed the records of 5 patients. Four of these patients had received regular diabetes reviews and had been followed up appropriately with medicine adjusted to improve their blood sugar control. We found that improvements were needed in recalling patients. For example, 1 patient had not been followed up with a planned face to face review after a raised blood result reading in October 2021. However, this patient had just been contacted to arrange monitoring blood tests and a foot check. Another patient had been advised to book a diabetes review and blood tests in September 2022, but this had not yet been arranged, again demonstrating the need for improvements in the practice's recall system. We saw an example of good practice where a vulnerable patient was given additional support by the practice in conjunction with the mental health practitioner to improve compliance with medication, which resulted in much better outcomes for the patient.
- There were 16 patients with a potential missed diagnoses of diabetes identified through the searches. The practice had recently completed a project to check patient records for potential missed diagnoses of diabetes and to ensure patient records were coded correctly. We reviewed the records of 5 patients. The practice had recalled these 5 patients to have repeat HbA1c tests to check if they had diabetes and 4 of these patients had appointments for blood tests. The records review showed again that improvements were needed in recalling patients. Two patients were advised to have their blood rechecked in a few months, but they had not been called in for the repeat tests at the appropriate time. For 3 patients best practice guidance on repeating the blood test to confirm a diagnosis of diabetes was not followed, suggesting a lack of awareness of the guidelines/criteria for diagnosing diabetes. The practice had identified this during their own audit and was planning to discuss guidance for diagnosing diabetes with clinicians.
- The practice offered statins to patients with cardiovascular disease.
- Medication reviews were being performed with the pharmacists offering structured medication reviews. Excellent examples of these were seen during the records review with templates being used to record information. The pharmacists had reviewed all medications including discussing compliance and side effects as well as checking monitoring. Some patients were overdue medication reviews as a result of the COVID-19 pandemic and the practice was in the process of

working through the backlog by contacting priority patients at greatest risk first.

- Evidence was seen from the records review of action being taken to amend medication after hospital discharge.
- The practice has a policy in place for issuing repeat prescriptions which was seen during the inspection.

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)	105	108	97.2%	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)	130	135	96.3%	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)	131	135	97.0%	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)	132	135	97.8%	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)	137	149	91.9%	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>

Any additional evidence or comments

The practice had met the minimum target of 90% in all five child immunisation indicators and had exceeded the 95% WHO target in four of the five indicators.

Cancer Indicators	Practice	SICBL 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: 30/06/2022) (UK Health and Security Agency)	70.0%	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)	16.9%	63.5%	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)	66.2%	69.1%	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)	56.8%	57.6%	55.4%	No statistical variation

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

Any additional evidence or comments
<p>Cervical cancer screening update data showed that the practice had not met the 80% national target for cervical cancer screening update. However, unvalidated QOF data showed that the uptake had since increased.</p> <p>The data available to the CQC showed a lower than average percentage of females aged 50 to 70 years having had screening for breast cancer. However, unvalidated data that the practice had obtained from the breast screening service following the inspection, showed that for the 2021 programme which took place between 31/3/21 and 31/5/21, that the overall uptake was 64%. The practice explained that their patients were recalled on a three year cycle, the last cycle being in April/May 2021, which was after the above data was captured.</p>

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

<p>The practice conducted quality improvement projects and audits. Examples of audits seen included:</p> <ul style="list-style-type: none"> • A two-cycle audit of cervical screening uptake, to identify health inequalities in cervical screening uptake in the population with a focus on people from ethnic minority backgrounds, people with a learning disability, severe mental illness or obesity. • Audit of patients with acute sinusitis to evaluate antibiotic prescribing against clinical guidance. • Audit of patients on nutritional supplements to assess the decision-making process for patients prescribed nutritional supplements against guidelines for treating malnutrition. <p>The practice had also undertaken some other quality improvement activities which included:</p> <ul style="list-style-type: none"> • Work with the Primary Care Network to review patients on dependence forming medications (e.g. high dose opioids, benzodiazepines and gabapentinoids). • An audit of the use of longer term courses of antibiotics to prevent urinary tract infections to make sure that appropriate monitoring checks were done and that the patients were not on these medications indefinitely. • An audit of potential missed diagnoses of diabetes. • A review of cancer decision support tools to help identify patients with suspected cancer.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence:	
The practice employed three non-medical Nurse Practitioner prescribers who were supervised by GPs. These prescribers were monitored by informal supervision and discussions with a GP if they had any prescribing queries. There was no formal monitoring of the non-medical prescribers.	

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
Explanation of any answers and additional evidence:	
<p>Weekly clinical team meetings were held to share information, for example safeguarding concerns and new guidance.</p> <p>Palliative care Gold Standards Framework (GSF) meetings were held every six weeks to discuss patients on the palliative care register. These were attended by the District Nurses and hospice staff.</p> <p>Out of hours (OOH) notifications were received electronically. The practice shared summary care records with OOH. An Information Technology system was used to share special patient notes (for example regarding palliative care) with OOH.</p> <p>District Nurses could be contacted by email or through a central point of access.</p>	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes

Any additional evidence or comments

The practice website provided patients with information on self-help in addition to information on BEAM - brief interventions in relation to the emotional wellbeing of children and young people under 25. The service provided advice, signposting and support with concerns these patients may have relating to feelings and emotional wellbeing.

The practice had access to a social prescriber who signposted patients to services such as smoking

cessation, weight loss and problem alcohol drinking support.

The Community Care Coordinator had established a Happy Opsy drop-in for lonely and socially isolated people and a carer's support group.

The practice was a Veteran Friendly Practice.

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Yes
Explanation of any answers and additional evidence, including from clinical searches:	
<p>Staff had received training on mental capacity as part of their essential training.</p> <p>The practice had a consent policy which was seen during the inspection.</p> <p>The practice did minor surgery and joint injections. Written consent forms were used for these procedures. Minor surgery audits had previously been undertaken to audit consent and infection rates.</p> <p>We saw evidence during our review of patient records of patients and their relatives being involved in end of life care discussions. ReSPECT forms were used to record patients' wishes and preferences (including those about resuscitation).</p> <p>The structured medication reviews seen that had been undertaken by the pharmacist included discussions about patient preferences.</p>	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

	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

Patient feedback	
Source	Feedback
CQC Give Feedback on Care	<p>As part of the inspection, we asked the practice to share the link to our Give Feedback on Care campaign so that patients could share their experience. We received a total of 7 responses from patients. In relation to providing caring services people told us:</p> <p>Staff were wonderful, very efficient, polite, professional and friendly and that they had been given excellent help by reception and during the consultation. One patient told us they felt listened to the whole time.</p>
Friends and Family Test (FFT)	<p>The practice had received 167 responses the FFT for the month of October 2022. One hundred and forty eight patients had rated the practice very good and 11 patients had rated the practice good for their overall experience. In relation to providing caring services staff were described as professional and courteous, cheerful and pleasant, supportive, very helpful, kind and caring.</p>

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	93.5%	86.4%	84.7%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	92.2%	85.2%	83.5%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	98.0%	94.6%	93.1%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	90.9%	73.4%	72.4%	Variation (positive)

Any additional evidence or comments

The practice had achieved higher results across all indicators for providing caring services compared with local and national averages.

Question

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

Any additional evidence

The practice had been involved in an 'Extended Access Survey' to gain patient feedback on things such as opening hours and preferred type and times of consultations.

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:	
The practice achieved higher than local and national averages for 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.	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	97.5%	91.4%	89.9%	Variation (positive)

	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:	
Interpretation services were available and the information on the practice website was available in a number of different languages. Patients could book into their appointment via a check in machine, which was available in different languages. The practice had tailored their information to meet the needs of a their patient population, which included a large number of patients of an ethnic minority group.	

Carers	Narrative
--------	-----------

Percentage and number of carers identified.	The practice had a carers register and had identified 374 patients as carers, 2.67% of the practice population.
How the practice supported carers (including young carers).	Patients had access to social prescribers as well as community and care coordinators who supported carers and signposted them to further help. They liaised and ran groups such as the "Happy Oddy" open group and carers support groups. Young carers had access to social prescribers that were based in schools and youth community hubs.
How the practice supported recently bereaved patients.	Information about an external bereavement service was displayed in a waiting area. Letters were also sent to bereaved patients.

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
Explanation of any answers and additional evidence: Staff we spoke with recognised the importance of people's dignity and respect. Arrangements were in place for patients to be offered a private room to discuss sensitive issues if required. During the inspection, we observed staff treating patients respectfully.	

Responsive

Rating: Good

At our previous inspection in September 2016, we rated the practice as outstanding for providing responsive services because:

- The practice had developed its staff's skillset in order that its clinical staff could deliver care directly at a refuge for domestic abuse patients with highly complex needs.
- The practice had devised a five point Dementia Action Alliance Action plan; including investigating the ways in which the practice physical environment could be improved to be more welcoming and accessible for patients with dementia, which was in progress.
- The practice had identified and liaised with local employers whose employees included 800 people from an ethnic minority group and provided literature in the most appropriate language to meet their needs.

At this inspection in November 2022, we found that those areas previously regarded as outstanding practice were now embedded throughout the majority of GP practices. While the provider had maintained this good practice, the threshold to achieve an outstanding rating had not been reached. The practice is therefore rated good for providing responsive services.

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
Explanation of any answers and additional evidence: Adjustments had been made to support patients. The practice had an Accessible Information Standard policy which was seen during the inspection. Pop-up alerts were used on patient records to identify any specific needs. Longer appointments were offered to patients with mental health problems and disabilities or women needing gynaecological examinations. The Community Care Co-ordinator had created a very useful support pack for patients who were homeless. This included information about the community support on offer, including the locations of food banks and contact details of the safer neighbourhood team.	

Practice Opening Times

Day	Time
Opening times:	
Monday to Friday	8.30am – 6pm

Appointments available:	
Monday to Friday	Times varied according to each clinician
	Extended Access pre-bookable appointments were available via a Hub during the evenings between the hours of 6.30pm and 8pm and on Saturdays between 9am and 5pm. .

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

	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 (including those who might be digitally excluded).	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
Explanation of any answers and additional evidence:	
Staff had been trained to signpost patients to relevant services for support e.g. First Access Physiotherapists, Community Pharmacists, Community Care Coordinator.	

The practice had links to the local Food Bank and we saw evidence of the practice providing food vouchers to patients during the remote records review.

The Community Care Coordinator supported patients by signposting them to local organisations for support such as Age Concern.

The practice contacted secondary care services for advice as needed.

One of the GPs specialised in supporting patients with drug and alcohol misuse problems.

The practice worked with a local charity 'Designs in Mind' where adults living with mental health challenges worked together on art and design projects.

The practice had stayed open on the day of the Queen's funeral to offer support to patients.

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	82.0%	N/A	52.7%	Significant Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	82.4%	57.0%	56.2%	Variation (positive)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	84.5%	54.7%	55.2%	Variation (positive)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	89.2%	74.0%	71.9%	Variation (positive)

Any additional evidence or comments

The practice had achieved higher results across all indicators for providing responsive services compared with local and national averages.

Source	Feedback
NHS website	No reviews had been posted on the NHS website in relation to this service.

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.	3
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
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: Information about how to make a complaint was available on the practice website and included the escalation process should complainants not be happy with how their complaint had been managed or the outcome.	

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: Leaders demonstrated they had identified and understood the challenges which included patient access due to increasing demand and getting the balance of face-to-face versus telephone appointments right. In response to these challenges, additional sessions had been added to improve patient access. The practice used to see most patients face-to-face before the COVID-19 pandemic and had to adapt to doing more remote consultations. This has led to the practice being more comfortable offering telephone consultations and all home visit requests were now triaged by telephone. Patients were now offered the choice of face-to-face or telephone appointments depending on their preference. The impact of the COVID-19 pandemic and resulting staff illness, had created a backlog in the completion of long-term condition and medication reviews. The practice used remote locums to provide services during the COVID-19 pandemic. The practice was fully staffed clinically, and they had recently recruited a new salaried GP to replace 1 who had left. A long-term locum was covering a salaried GP who was on maternity leave.	

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: The aims and objectives of the practice were: <ul style="list-style-type: none">• To ensure high quality, safe and effective services for their patients.• To optimize performance against key targets and core standards.• To recruit, retain and develop a highly motivated and skilled workforce.	

- Financial sustainability and probity.

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.	Partial
Explanation of any answers and additional evidence: We checked the practice's training matrix as well as staff files, and found that not all staff had undertaken training in equality and diversity.	

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

Source	Feedback
Discussions with staff	<p>Staff told us that it was a nice practice to work at and that it benefited from a low turnover of staff. They told us that the team was made up of experienced, committed and hardworking staff that had worked at the practice for many years. They told us that the culture was friendly, and it was like being a part of a family. There was an open-door policy within the practice and staff felt there was good communication and team working in the practice.</p> <p>Staff told us that it was a busy practice, but not unmanageable and demands from patients were high. They told us they felt appreciated and were thanked when they stayed on to help or when they provided additional cover.</p> <p>Staff commented that the level of support was high, that there was always someone there to help them during times of professional and personal struggles.</p>

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
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Explanation of any answers and additional evidence:	
<p>There were clear lines of accountability and staff we spoke with were confident about their roles and accountabilities. Staff had lead roles and responsibilities for examples in areas such as safeguarding, prescribing and infection, prevention and control (IPC). Practice policies and procedures were available to staff on the practice intranet site.</p> <p>The practice held a range of meetings to share and discuss a range of information, including regular partner meetings to discuss governance arrangements.</p>	

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

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

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
Staff are supported to work remotely where applicable.	Yes

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Partial
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence:	
The practice's Patient Participation Group (PPG) was affected by the Covid-19 pandemic with meetings having to be postponed for everyone's safety and wellbeing. The practice manager was working on re-establishing the group with a date set for the group to meet in December 2022. The practice website included information on how patients could join the PPG, and there was an open invitation for all population groups to join.	

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.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	
<p>The practice was a training practice for GP trainees with 3 GPs trained as trainers. The practice also offered medical student training and apprenticeships in association with Keele University. A number of GP trainees and apprentices had stayed on at the practice after completing their training.</p> <p>Regular staff meetings were held to discuss improvements and learning. Protected Learning time sessions were held regularly to provide training and share learning. The practice supported staff in developing their skills (e.g. Nurses to become Nurse Practitioners, Urgent Care Practitioners to become prescribers).</p> <p>The practice had access to the NB Medical Hot Topics training courses and webinars to stay up to date.</p> <p>The practice was part of the North Shropshire Primary Care Network (PCN) along with another 5 practices. The practice manager was the lead manager for the PCN and the practice was also the lead finance practice for the PCN. They attended regular PCN manager and board meetings.</p> <p>The practice worked with Public Health and Integrated Health Board to support the covid-19 vaccination programme, which included supporting the setup of the vaccination hub within the local hospital. They provided vaccinators and administrators.</p>	

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 SICBL 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 SICBL 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.