



Care Quality Commission

Inspection Evidence Table

The North Leeds Medical Practice

(1-574141809)

Inspection Date: 19 May 2023 and 24 May 2023

Date of data download: 10/05/2023

Overall rating: Good

We previously inspected the practice in August 2021 when they were rated requires improvement overall and for providing safe, effective and well-led services. We rated the practice good for providing a caring and responsive service.

At this inspection, we found that those areas previously regarded as requiring improvement had now been addressed and improvements made. The practice is therefore now rated good.

Safe

Rating: Good

At the last inspection in August 2021, we rated the practice as requires improvement for providing safe services because we found issues relating to reviews of policies and procedures, Disclosure and Barring Service checks for staff, fire safety, health and safety risk assessments, out-of-date emergency equipment, learning from incidents and competency checks on appropriate staff.

At this inspection, we found that improvements had been made in these areas. The practice is therefore now rated good for providing safe services.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes

Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff had completed the appropriate level of safeguarding training for their roles. • There was a safeguarding lead and deputy in place. All clinical and non-clinical staff we spoke with knew who the safeguarding lead at the practice was. We saw that the lead attended external safeguarding meetings and that clinicians attended daily catch-up meetings to discuss any new concerns. • There were policies and procedures in place to support safe systems and processes in the practice, and these had been reviewed since the last inspection. There was a combined safeguarding policy and this was accessible to staff. • There were systems in place to follow-up on children with frequent attendance at accident and emergency, and when children had not been taken to secondary care appointments. • There was a programme in place to ensure that all staff received an appropriate DBS check. • We saw that staff responsible for chaperoning had received appropriate training for this role. • As part of this inspection, we reviewed safeguarding records and found appropriate identification, coding and flagging of vulnerable children and adults. There was, however, no coding in place for parents with children on the safeguarding list. We saw that after the inspection this had been discussed in the safeguarding meeting and the practice told us they would perform a search of relevant parents and code them appropriately. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We saw checklists were used for new starters and locums which documented all the necessary information, checks and procedures required. • We reviewed 4 staff recruitment files which included 1 non-clinical staff member and 1 locum clinical staff member and found relevant employment documentation in place. However certain checks, including ID and performers list checks, were not documented as having been carried out. The practice told us that these checks were carried out at the recruitment stage but not recorded. 	

- Immunisations were based on self-declaration, with only evidence of Hepatitis B status required from clinical staff. We saw that the self-declaration form contained details of the vaccinations required and that staff were asked for supporting documentation.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: December 2022 (both sites)	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: September 2022 (both sites)	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The main site is a purpose-built health centre with an adjoining pharmacy. The premises have disabled access and upper floors can be accessed either by the stairs or lift. • The branch site was originally a residential house, which was converted to GP premises. There is disabled access via a ramp. Access to the upper floor is by stairs. Patients with limited mobility are offered a room downstairs. • At the main site there was CCTV in operation and appropriate signage in place to inform patients of this, however the CCTV on the 1st floor waiting area was not monitored. After the inspection the practice had started looking into how they could monitor the 1st floor waiting area at the main site. There was no CCTV at the branch site. We saw that there was work in place to move services from the branch site into a new health centre. The practice told us that CCTV would be installed at the new site. • We reviewed maintenance records for both locations and saw the practice had undertaken fire alarm and fire extinguisher servicing. We saw evidence of actions undertaken in response to concerns highlighted in the service report. • Fire alarm checks were carried out weekly. There had been a fire evacuation drill at the main site in January 2023 and at the branch site in April 2023. Smoke alarms which were previously identified as a non-compliance recommendation, had been replaced. • We saw evidence of a gas safety certificate, portable appliance testing (PAT) and calibration of medical equipment at both locations. There was an electrical fixed installation condition report for the main site. We were told that the practice was trying to get someone to carry out the report for the branch site but had not yet managed to do this. • We saw evidence of lift maintenance at the main surgery. • We saw there had been an assessment for Legionella undertaken at both locations in January 2023 and that hot and cold-water temperature testing was carried out regularly. • Training records showed that all staff had undertaken fire awareness training, which was updated annually. Fire marshals had undertaken training for their role. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: August 2022 (main site) March 2023 (branch site)	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • On the day of inspection, we observed the main surgery and the branch surgery to be clean and tidy. • There was a nominated infection prevention and control (IPC) lead. All staff we spoke with knew who the lead was. • All staff had undertaken IPC training relevant to their role and refresher training was undertaken annually. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Non-clinical staff provided cover for one another when required. Locums were used to provide cover for clinical staff members. • We saw that clinical and non-clinical staff had undertaken basic life support and sepsis awareness training. • We saw that there was emergency medical equipment held at both practice locations, for example oxygen and an automated external defibrillator (AED). Staff were aware of their location. • The practice utilised the panic alarm system integrated into their clinical system. Staff we spoke with were aware of how to raise the alarm in the event of an emergency. • Some staff told us they felt there were not always enough reception staff to cover duties. The practice told us they had had difficulties retaining reception staff and that they were regularly recruiting additional staff to cover the gaps. 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> As part of our inspection, the CQC GP specialist advisor reviewed a selection of patient records without visiting the practice. These searches were visible to the practice. We saw that patient consultations contained appropriate information and demonstrated that care and treatment was being delivered in a safe way. Clinical records of new patients were received by electronic transfer or as paper records. All paper records were available and securely stored at the practice. There was a summarising policy and a system in place to ensure that patient information that had not yet been summarised was available to them when required. There was a policy and system in place to ensure that referrals were dealt with in a timely way. Urgent two-week referrals were dealt with appropriately and there was additional safety-netting in place to ensure that referrals were not missed. There was a system in place to ensure test results and patient correspondence were managed during staff absences. 	

Appropriate and safe use of medicines

The practice had 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	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) <small>(NHSBSA)</small>	0.72	0.90	0.86	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). (01/01/2022 to 31/12/2022) (NHSBSA)	5.2%	6.4%	8.1%	Tending towards variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim	4.08	4.58	5.24	Variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	81.3‰	114.1‰	130.3‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	0.41	0.45	0.56	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	3.7‰	4.8‰	6.8‰	Tending towards variation (positive)

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

Any additional evidence or comments

- The practice had achieved good prescribing outcomes as some of their prescribing was below local and national averages. They told us they routinely distributed Lowering Antimicrobial Prescribing (LAMP) reports to clinicians to monitor and raise awareness of their antibiotic prescribing. There was a prescribing lead who attended peer review meetings. We saw that prescribing was a standing agenda item at clinical meetings.

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.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes

There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	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.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>As part of our inspection, we conducted a series of searches to assess the practice's procedures around medicines management and prescribing.</p> <ul style="list-style-type: none"> • A search of patients prescribed a disease-modifying antirheumatic drug (DMARD) showed that overall patients were managed in line with guidance. For example, we found of 64 patients prescribed the medicine methotrexate (a drug used to treat inflammatory autoimmune conditions like rheumatoid arthritis) 5 had not had the required monitoring in the last 6 months. It was identified that 2 of these patients were under hospital monitoring, but the provider was not routinely recording that this indicated it was safe to continue prescribing the medicines. We also found that the day of the week that the medicine was to be taken was not always recorded. Immediately after the inspection the practice reviewed their processes and said they would discuss the findings at their next clinical meeting in order to raise awareness. • We found 53 patients who had been prescribed potassium sparing diuretics (a medicine used to treat conditions such as heart failure and high blood pressure) and had a diagnosis of heart failure. Out of these, 11 patients had been identified as not having had the required blood test monitoring carried out or recorded in their medical notes. Immediately after the inspection the practice told us they had reviewed these patients and would be contacting them for a blood test or review where required. • We saw that medicines reviews had been undertaken by the practice and that these were of a good quality and included evidence of detailed discussions with patients. • Appropriate emergency drugs and equipment was held at both sites. We saw evidence of some expired needles at the branch site. These were immediately discarded and replaced. Risk assessments had been undertaken for those medicines not stored. The practice had a system in place to check stock levels and expiry dates and we saw records of these. • We saw that vaccine refrigerators at both sites were in good working order and there were records of twice daily temperature checks. 	

- We saw that blank prescriptions were locked in a secure cabinet. However, there was no process in place to document serial numbers on receipt, and when taken away for use by staff. After the inspection the provider told us they were reviewing their processes and would begin to document serial numbers.
- There was a non-medical prescriber policy and a process in place to review prescribing practices annually at appraisals, or more often if any concerns were identified.

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:	101
Number of events that required action:	84
Explanation of any answers and additional evidence:	

- The practice had a significant event policy in place, which was accessible to staff.
- There was a process in place for reporting and recording incidents and there was a nominated GP who was the incident lead. We saw that there had been 101 reported incidents over the last 12 months, 84 of which had been investigated and action taken with a later discussion in a designated significant events meeting. The remaining 17 events were in the process of either being investigated or awaiting discussion in the next meeting. We saw that events had been summarised to identify trends.
- Staff told us they were aware of the process to report an incident and said they felt confident to do so.
- We reviewed a selection of incidents and saw appropriate action had been taken and learning shared through meetings.

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

Event	Specific action taken
An appointment was given to a patient requesting a fit to work note despite them already having completed an e-consultation, and this resulted in a wasted appointment.	The process for providing fit to work notes was changed. Face to face appointments for fit to work notes alone were no longer provided.
E-consultation notes added to another patient's record, resulting in a breach of confidentiality.	Duty of Candour was followed as the patient was informed of the breach. Reception staff were reminded to check patient details when adding e-consultations to records.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • There was a protocol in place for managing safety alerts. The practice had systems and processes in place to receive, disseminate and act upon alerts received through the Medicines and Healthcare products Regulatory Agency (MHRA). The practice pharmacist dealt with all medicines related safety alerts. • The practice maintained a log of all safety alerts received and action taken. • A search of clinical records was carried out for patients prescribed Citalopram (a selective serotonin reuptake inhibitor indicated for the treatment of major depressive disorder, panic disorder, and obsessive-compulsive disorder), and who were over the age of 65. Elderly patients have a higher exposure due to age-related decline in metabolism, so the maximum dose of this medicine has been restricted in patients older than 65 years. The search identified 2 patients and 1 of these had not been reviewed and informed of the risks involved, however this patient had turned 65 recently. After the inspection the practice told us they had reviewed the patient and their processes. 	

Effective

Rating: Requires Improvement

At the last inspection in August 2021 we rated the practice as requires improvement for providing effective services because we found that the uptake rates for childhood immunisations and cervical cancer screening

had been consistently lower than the local and national averages.

At this inspection we found that although the practice had taken action to try and improve in this area, uptake rates continued to be low. The practice therefore remains rated as requires improvement for providing effective services.

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients’ immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients’ treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients’ needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice prioritised care for their most clinically vulnerable patients.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We undertook a clinical record search and saw that care and treatment for patients was delivered in line with current evidence-based practice. • Staff told us they were kept up to date with current evidence-based guidance through clinical meetings and in practice protected time. 	

Effective care for the practice population

Findings

- Staff told us they were kept up to date with current evidence-based guidance through clinical meetings and in practice protected time.
- 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.
- All patients aged 75 years and over had a named GP.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. Follow-up and reviews of patients were undertaken where risk factors or abnormalities were identified.
- The practice had 85 patients coded with a learning disability, of which 63 had been offered a health check in the last 12 months. Of these, 52 patients had received the health check.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. They had support from the Primary Care Networks (PCNs) in the form of occupational therapists, social prescribers, patient ambassadors, and Healthy Minds (a community programme to help those who may be struggling with their mental health, isolation or social exclusion). At the time of inspection, the practice had completed 82% of mental health care plans.
- Patients at risk of dementia were identified and an assessment tool used to detect possible signs of dementia. Referrals were made for those patients in whom dementia was suspected.
- The practice supported housebound and vulnerable patients, such as those on palliative care. Palliative care meetings were held monthly and attended by a GP and a nurse from the local hospice. There was a GP who undertook home visits every day for housebound patients. Nurses also undertook home visits where required, for example for vaccinations or blood tests.
- The practice provided clinical care for registered patients who lived in two local residential/nursing homes. One GP was allocated to do this to ensure continuity of care. Weekly visits were undertaken to carry out proactive reviews of the patients.
- End of life care plans, including details of patients' preferred place of death, were in place as appropriate.

Management of people with long term conditions

Findings

- As part of the inspection, a number of clinical record searches for patients with long-term conditions was undertaken by a CQC GP specialist advisor (SpA). Our searches found:
 - There were 37 patients with chronic kidney disease (CKD) stage 4 or 5 on the practice's register, 1 of these patients had not had a urea and electrolytes test recorded within the required time period. However, there was evidence that this patient had been reviewed elsewhere.
 - There were 1,891 patients with asthma on the practice's register. We saw there were 112 patients who had been prescribed 2 or more courses of rescue steroids in the last 12 months. We reviewed 5 patients and found that 1 of these patients had not had an asthma review in the last 12 months, and 1 patient had not received a steroid treatment card. We saw that all 5 patients had received an adequate assessment at the time of prescribing rescue steroids. After the inspection the practice told us they would identify all patients requiring a steroid treatment card and ensure that this was provided to them.
 - There were 1,082 patients with diabetes on the practice's register. We saw there were 67 patients with diabetic retinopathy whose latest HbA1c was more than 74mmol/l. We reviewed 5 patient records and found that there were appropriate interventions in place and that structured medication reviews had been undertaken.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. There were specialist nurses to lead on areas such as diabetes and respiratory.
- There was a blood pressure (BP) machine loan system in place for patients to enable them to monitor and check their BP at home.
- There was a chronic pain group and men's mental health group service available to patients at the branch site.

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 influenzae type b (Hib), Hepatitis B (Hep B) (i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	258	306	84.3%	Below 90% minimum

The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	248	321	77.3%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	250	321	77.9%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	249	321	77.6%	Below 80% uptake
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	269	373	72.1%	Below 80% uptake

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

Any additional evidence or comments

- The practice was aware that they had not met the WHO based target of 95% (the recommended standard for achieving herd immunity) for their childhood immunisation uptake indicators.
- We saw that there had been a steady increase in uptake rates from March 2021 to March 2022.
- We were informed of the differences of the patient demographics at the two sites, which impacted on a lower uptake rate at the branch site. For example, we saw unverified data from 2021/22, provided by the practice, which showed 91% achievement for the main site compared to 57% for the branch site, for children aged 2 who had received immunisation for measles, mumps and rubella (MMR). The practice therefore concluded that a different approach was needed for patients at the branch site.
- We saw that the practice had actively engaged with the PCN and the Office for Health Improvement and Disparities in order to develop new ways of engaging with the branch site population and increase uptake rates. For example, we saw that they were taking part in a project to create letters and messages in various languages to relieve the barriers of communication with the population.
- The practice told us they had arranged for a member of Leeds Community Healthcare to look into their vaccine recall system, in order to try and streamline the process and improve on areas such as missed appointments.
- In response to a recent confirmed case of measles in the region, the practice had taken the opportunity to contact patients with an outstanding MMR vaccination to inform them of the rise in measles and to attend the practice for a vaccine.
- Information and awareness of childhood immunisation was provided to support parents/guardians to make informed decisions.
- The practice had systems and processes in place to identify and follow-up on children who were not brought to scheduled childhood immunisations. If a child missed an appointment the practice contacted parents to establish a reason for the missed appointment and to arrange another appointment for the child.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	53.8%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	62%	N/A	70.3%	N/A
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). (30/09/2022 to 30/09/2022) (UKHSA)	57.2%	N/A	80.0%	Below 70% uptake
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	45.2%	48.7%	54.9%	No statistical variation

Any additional evidence or comments
<ul style="list-style-type: none"> • The practice was aware that their cervical screening uptake was below the 80% national target. We saw that there had been a steady decline in uptake rates from March 2022 to December 2022. • We were informed of the differences of the patient demographics at the two locations, which impacted on a lower uptake rate at the branch site. For example, we saw unverified data from 2021/22, provided by the practice, which showed 93% achievement for the main site compared to 80% for the branch site, for smears performed in the last 3 years for patients aged 25-49. The practice therefore concluded that a different approach was needed for patients at the branch site. • We saw that the practice had actively engaged with the PCN in order to develop new ways of engaging with the practice population and increase uptake rates. • The practice had a cancer screening champion who actively worked to promote uptake rates. They contacted patients who were eligible for screening and where appointments had been missed. They also attended peer meetings and engaged with the ICB to develop new approaches to increase uptake. For example, they told us they were looking into contacting specific community groups who may be able to suggest new approaches to engaging with those communities. • The practice told us they had improved the cervical screening templates used to send out invitations and this included easy read letters designed to assist patients with learning difficulties. • Both practice sites offered cervical screening appointments in extended access clinics. • There was a system in place to ensure a result was received for every cervical screening sample sent. • The practice told us they had had difficulties getting enough trained nurses to carry out cervical screening. They told us they were in the process of training another nurse in order to increase numbers.

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
<ul style="list-style-type: none"> We saw a range of audits, some of which were two-cycle and could evidence where changes or improvements had been made. The audits had been presented at clinical meetings, where information and learning were shared and discussed amongst the clinicians. <p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ul style="list-style-type: none"> ACR (urine albumin to creatinine ratio) testing in patients with diabetes: This 2-cycle audit looked into how often patients who had a diabetes review also had an ACR result recorded in their clinical notes. Over a 6-month period it was found that 71.4% of patients who had a diabetes review also had their ACR tested. In response to this the practice added a reminder to the diabetes recall letters to bring a urine sample when seen by the nursing team, a reminder in the diabetes appointment template for reception to remind patients when booking the appointment, and a leaflet for reception/nursing team to give to patients for them to understand why ACR testing is important for their care. A re-audit carried out 6 months later showed an increase of 1.7% from the initial audit. They planned to re-audit again in 6 months' time. Prescribing of Co-amoxiclav: The practice identified 27 patients had been prescribed co-amoxiclav in an 8-week period. They reviewed 16 of these patients and found that generally prescribing was acceptable. There was one case of incorrect antibiotics not suitable for the indication as per guidelines, and one out of hours prescribing with no indication recorded. The results were discussed in a clinical meeting and as a result the practice planned to take steps to ensure that clinical indication is documented in the patient's notes, that guidelines for correct duration of antibiotics treatment are checked, and that the clinical template is adapted to local antimicrobial guidelines. They planned to re-audit in 3 months' time. The practice participated in the Lowering Antimicrobial Prescribing (LAMP) audit and feedback project and as a result had a good understanding of their overall prescribing performance. 	

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• We saw that the practice had a mandatory training schedule in place for clinical and non-clinical staff. Training included safeguarding children and adults, infection control, basic life support, data security awareness, information governance, fire safety, anaphylaxis, sepsis awareness, learning disability and autism awareness, moving and handling, and equality and diversity training. There were systems in place to monitor when mandatory training updates were due.• Staff were encouraged and facilitated to complete all mandatory training identified by the practice. We saw that staff were given protected time to undertake their training, however some staff felt that this was not enough time and that this resulted in them having to carry out training in their own time.• There was a structured process in place for support and clinical supervision of non-medical prescribers. There was a non-medical prescriber policy in place.	

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

	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:	

- The practice told us they worked closely with other organisations to ensure patients received care in a coordinated manner. This included the establishment of close working relationships with, for example, the health visiting teams.
- The practice liaised with two local residential care/nursing homes. Weekly visits were undertaken to carry out proactive reviews of the 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.	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice provided social prescribing sessions which helped patients improve their health, wellbeing, and social welfare by connecting them to community services. • A local registered charity providing safe and accessible social activities such as chair exercises and art therapy was available at the main site 1 day a week and the practice encouraged patients to take part in these activities. • A range of health checks and reviews were offered for patients, where they were encouraged to be involved in managing their own health. • The practice offered appointments to patients to discuss how they can lead a more active lifestyle. • Staff had been trained in care navigation and were able to signpost patients to other services and support where appropriate. 	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Clinical staff we spoke with understood the requirements of legislation and guidance when considering consent and decision making.• As part of our inspection, we reviewed a sample of DNACPR decisions made within the last 12 months. We saw that comprehensive records had been maintained, and this included an assessment of the patient's mental capacity.	

Caring

Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• On the day of the inspection, we observed that staff spoke with patients in a dignified and respectful manner.• We saw that equality and diversity training was part of the mandatory training requirements and that all staff were up to date with this training.	

Patient feedback	
Source	Feedback
GP Patient Survey 2022	Data indicated that patient satisfaction in relation to care was in line with local and national averages.

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	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)	84.1%	86.2%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	86.5%	85.2%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	94.9%	93.7%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	69.7%	74.1%	72.4%	No statistical variation

Any additional evidence or comments

- As part of our inspection we reviewed the outcomes of the most recent National GP Patient Survey and NHS Friends and Family Test (FFT).
- Data from the GP Patient Survey 2022 indicated that patient satisfaction in relation to care was in line with local and national averages.
- We reviewed the responses to the FFT for April 2023 and saw that out of 224 responses, 90% of patients would recommend the service to others.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	No

Any additional evidence

- There had been no patient surveys carried out in the last 12 months. We saw that the practice's Patient Participation Group (PPG) was in the process of putting together a patient survey.

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:	
<ul style="list-style-type: none"> • There was access to a hearing loop in the practice, for patients who may be hearing impaired. • We saw that there was advice and information available for carers at both sites and on the practice website. 	

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	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)	90.9%	90.0%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes
Explanation of any answers and additional evidence:	

- There was access to translation and interpreting services as needed.
- The practice told us they offered longer appointment times where necessary, for example for those patients who did not have English as a first language.
- Material was available to patients in a range of languages.

Carers	Narrative
Percentage and number of carers identified.	2% (330 patients) had been identified as carers.
How the practice supported carers (including young carers).	Information for carers was available on the practice website and promoted on patient information boards at both sites. There was a nominated carers' champion in the practice.
How the practice supported recently bereaved patients.	Information for bereaved patients was available on the practice website and promoted on patient information boards at both sites.

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:	
<ul style="list-style-type: none"> • On the day of inspection, we observed confidentiality at the reception desk. We saw the computer on the reception desk was positioned so patients could not view the screen. • We saw that information governance and data security awareness training was part of the mandatory training schedule and that all staff were up to date with this training. 	

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes

The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Harrogate Road Surgery operates from a modern purpose-built health centre. This site is located in an area of low deprivation with a predominantly white British population. The service at the branch site (Milan Street Surgery) is provided from a residential property which has been converted to a GP practice. This site is located in an area of high deprivation with a predominantly multi-cultural and ethnic population. • Due to the locations of the two practice sites, they are situated in two different Primary Care Networks (PCNs) which support delivery of services relevant to those patient populations. A range of services were offered to support the needs of the practice population across both sites. • The premises at the main site had disabled access and upper floors could be accessed either by the stairs or lift. Patients who attended the branch site, and had any mobility difficulties, were seen in downstairs consulting rooms. • The practice understood the challenges brought about by the branch site, particularly in terms of the shortage of space available to staff and patients. We saw that there was work in place to move services from this site into a new health centre. This work was scheduled to be completed in October 2023. • Patients were able to access longer appointments where required. • There was access to translation and interpreting services as needed. • We saw that all staff had undertaken Accessible Information Standard training as part of the practice's mandatory training schedule. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am - 6pm
Tuesday	8am - 6pm
Wednesday	8am - 6pm
Thursday	8am - 6pm
Friday	8am - 6pm
Appointments available:	
Monday	8.20am – 5.30pm
Tuesday	8.10am – 5.30pm
Wednesday	8.20am – 5.20pm

Thursday	8.10am – 5.20pm
Friday	8.20am – 5.30pm

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

- The practice told us that appointment times varied slightly each day as flexibility was given to clinicians for their clinics.
- Appointments were available to book in advance and on the day.
- Protected appointment slots were available for school age children so that they did not need to miss school.
- Additional extended access appointments were provided by each of the PCNs. For the Harrogate Road site services run from 8am to 8pm Monday to Friday, from 8am to 1pm on Saturdays, and from 9am to 1pm on Sundays. For the branch site services run from 8am to 8pm Monday to Friday, from 9am to 5pm on Saturdays, and from 9am to 1pm on Sundays.
- All patients aged 75 years and over 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 provided clinical care for registered patients who lived in two local residential/nursing homes. One GP was allocated to do this to ensure continuity of care. Weekly visits were undertaken to carry out proactive reviews of the patients.
- Patients could register as an online patient via the practice website. They could also register for electronic prescribing and have their prescriptions sent to the pharmacy of their choice.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- The practice held a register of patients living in vulnerable circumstances including housebound patients 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.

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 minimise 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:

- Patients could access appointments by telephone, video, in person or via e-consult.
- Staff had been trained in care navigation and were able to signpost patients to other services and support when this was appropriate.
- The practice website contained information regarding services delivered at the surgery as well as services delivered by other organisations.

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	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)	42.1%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	54.3%	57.9%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	53.0%	56.1%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	65.8%	73.6%	71.9%	No statistical variation

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.	89
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • There was a complaints policy in place. • The practice had a complaints lead and a patient liaison officer. • Information about how to complain was available for patients on the practice website. • We reviewed 3 complaints and saw that they had all been dealt with appropriately and in line with the practice policy. Details regarding the Parliamentary and Health Service Ombudsman (PHSO) were made available for complainants to escalate their complaint as appropriate. • The complaints had been summarised and a review of any themes undertaken. It was noted that many of the complaints related to access to appointments. • The practice told us they had an overall reduction in the number of complaints upon the previous year and they felt that this reflected their willingness to respond positively to feedback. They also told us that providing more thorough and detailed complaint responses meant that patients were more satisfied with the initial response. 	

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes

Example(s) of learning from complaints.

Complaint	Specific action taken
Referral not completed for patient	Apologised to patient for delay in referral process. Explained delay was caused by clerical error. Training and feedback given to staff member involved.

Well-led

Rating: Good

At the last inspection in August 2021 we rated the practice as requires improvement for providing well-led services because we found issues relating to governance processes, risk assessments, and

staff not being aware of the vision, values and strategy of the practice or the Freedom to Speak up Guardian.

At this inspection we found that improvements had been made in these areas. Staff were aware of who the Freedom to Speak up Guardian was and had been involved in developing the strategic planning of the practice. The practice is therefore now rated good for providing well-led services.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had an experienced leadership team in place, who understood the challenges to healthcare. • The leadership team were open about the recent challenges, in particular the retention of reception staff, periods without a practice manager in place, and the small, outdated premises at the branch site. They had recruited a new practice manager who was due to start in post in June 2023. Work was being undertaken to move services from the current branch site into a new health centre and it was planned that this would improve patient care and experience, and staff wellbeing. • The practice discussed the challenges of the branch site being situated in an area of high deprivation. Some patient cohorts were difficult to engage in health initiatives. The practice had focused specifically on patient engagement for childhood immunisation and cancer screening. We saw that the practice had actively engaged with the Primary Care Network (PCN) and Office for Health Improvement and Disparities in order to develop new ways of engaging with the practice population and increase uptake rates. • The practice was responsive and proactive to feedback during the inspection process and acted upon our findings and feedback. • Staff told us they felt members of the management team were approachable and supportive. • The practice had developed a tier system to support salaried GPs take on extra roles and responsibilities gradually, to prepare them in becoming a GP partner should they wish to do so. 	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had a clear vision and strategy in place. They told us their vision was ‘to provide quality patient-centred care’. We saw that the vision and strategy had been reviewed in October 2022 and that several ideas had been implemented and others in progress. For example, we saw that the practice was planning to develop group consultations to support patients with long-term conditions.• Staff told us they thought the practice had a clear vision for the future and that they had been involved in developing the strategic planning of the practice.	

Culture

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

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

- The practice had access to a Freedom to Speak Up Guardian. Staff were aware of who this was, and we saw information about this on display at the practice.
- We reviewed complaints and saw that they had all been dealt with appropriately and in line with the practice policy. Where required, people had received an apology and appropriate actions taken.
- We saw that equality and diversity training was part of the mandatory training schedule and that all staff were up to date with this training.

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

Source	Feedback
Staff words used in questionnaires.	Words used to describe the team included friendly, approachable, and dedicated.
Staff words used in questionnaires.	One staff member told us how during periods of training, they had been supported by their manager and the partners at the practice.

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: <ul style="list-style-type: none"> • Staff had access to policies, procedures and protocols and knew how to access these. • The practice had nominated leads for key areas, such as the safeguarding of adults and children and infection prevention and control, whom staff could contact for specialist advice and support. Staff were aware of who the leads were. • The practice had a regular meeting structure which included daily catch-up meetings for clinicians, and monthly practice, nurse and clinical meetings. 	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We saw a range of audits, some of which were two-cycle and could evidence where changes or improvements had been made. • There was a business continuity plan in place. 	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice was aware of their patient outcomes and performance and used the information to decide on which areas to action in order to improve performance and maintain targets. 	

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.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice monitored patient feedback through the GP National Patient Survey, the NHS Friends and Family Test (FTT), complaints and compliments. 	

- The practice had an active Patient Participation Group which held regular meetings at the main site. Meetings were usually attended by the practice manager, however in the absence of a practice manager a GP would attend.
- Staff told us they could provide feedback through meetings and that they felt their views were taken on board.
- We saw that the practice had worked with the PCN and Public health England in order to develop new ways of engaging with the practice population at their branch site.

Feedback from Patient Participation Group.

Feedback

The PPG told us that they had a good relationship with the practice and that they felt their views were listened to and acted upon.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Staff told us they had protected time for training and to attend meetings, and that they were able to set learning objectives in their yearly appraisals. • The practice trained and supported staff to take on new roles. For example, they were supporting a prescription clerk to undertake training as a pharmacy technician. • We saw that the practice reviewed incidents and complaints and that these were discussed at meetings and used to make improvements or changes to the way services were delivered. 	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

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

Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.

- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

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

