

Care Quality Commission

Inspection Evidence Table

Dr Jerome Kaine Ikwueke (1-496222451)

Inspection date: 22 July 2021

Date of data download: 21 July 2021

Overall rating: Inadequate

- There were inadequate systems in place to manage risks associated with emergency situations.
- There was little evidence of learning from events or action taken to improve safety; and arrangements for disseminating and acting on safety alerts placed patients at risk.
- Systems, processes and practices for monitoring high risk medicines did not keep patients safe.
- We saw instances of where people did not receive effective care or treatment (for example, undiagnosed diabetes and missed annual asthma reviews).
- Complaints were handled inappropriately and we did not see evidence of discussion, shared learning or how complaints led to improvements in the quality of care.
- Patient feedback was above local and national averages regarding phone and appointments access. Patients fed back that they could access the right care at the right time.
- Governance arrangements hindered the delivery of high-quality care (for example regarding staff induction arrangements and arrangements for acting on safety alerts).

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe

Rating: Inadequate

- There were inadequate systems in place to manage risks associated with emergency situations.
- There was little evidence of learning from events or action taken to improve safety; and arrangements for disseminating and acting on safety alerts placed patients at risk.
- Systems, processes and practices for monitoring high risk medicines did not keep patients safe.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	N
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: When we reviewed a selection of personnel records, we noted the absence of DBS checks and references for the practice's two part time locum nurses. This was not in accordance with the practice's recruitment policy.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N

Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence: Recruitment checks were not always carried out in accordance with regulations (see section above).	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 18.7.21	Y
There was a record of equipment calibration. Date of last calibration: 22.6.21	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: 22.6.21	Y
Actions from fire risk assessment were identified and completed.	No actions identified
Explanation of any answers and additional evidence: We saw evidence of recent servicing of fire extinguishers and fire alarm, although the practice's fire safety policy was not version controlled and so it was unclear if it reflected current fire safety protocols. 31/07/2019 calibration	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: January 2000	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 3.6.21	Y
Explanation of any answers and additional evidence: A premises/security risk assessment was carried out in January 2000 and resulted in the installation of security grilles.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 16.4.21	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: We saw evidence the practice had acted on issues identified in its April 2021 Infection Prevention and Control (IPC) audit. For example, shelving had been redesigned in the nurse's room, to prevent dust build up and minimise infection risks. However, we noted that the provider's last IPC audit, prior to April 2021, had taken place in 2018. A water sample analysis was undertaken in April 2021 and confirmed the absence of Legionella from the building's water system (Legionella is a bacterium which poses a health risk and which can proliferate in building water systems).	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	N
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	N
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
Explanation of any answers and additional evidence:	

Induction Systems

We were not assured of an effective induction system for temporary staff tailored to their role. For example, leaders were unable to provide signed confirmation that the practice's Locum GP had undergone formal induction. We also found that the practice's Induction Check List document was not dated, or version controlled and so it was unclear as to whether the protocols it referenced were current. We could not be assured that induction arrangements ensured that temporary staff had access to accurate information that would allow them to safely and effectively manage patients.

Medical Emergencies

We could not be assured staff understood their responsibilities in the event of an emergency with regards to the location of medicines. When we inspected on site, we did not see evidence of a written emergency medicines protocol, clearly defining lead staff member responsibility and where each emergency medicine should be located. Consequently, staff with whom we spoke could not initially locate the practice's emergency Adrenaline and we noted the practice was not undertaking periodic checks of its emergency oxygen and defibrillator.

Shortly after our inspection we were sent a copy of the provider's emergency medicines protocol. This document mandated that staff undertake periodic checks of the practice's emergency oxygen and defibrillator. We also noted the practice could not provide evidence that nurses had had basic life support training in the last 12 months.

Information to deliver safe care and treatment

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

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

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.45	0.51	0.70	Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2020 to 31/03/2021) (NHSBSA)	11.4%	12.2%	10.2%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2020 to 31/03/2021) (NHSBSA)	5.49	5.89	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	99.3‰	60.5‰	126.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	0.30	0.63	0.66	Tending towards variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	7.8‰	6.2‰	6.7‰	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.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	n/a
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	n/a
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	n/a
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.	N
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence:	
<u>Patient Group Directions</u> Appropriately signed and counter signed Patient Group Directions were on site but we noted they had been dated with a month and year convention as opposed to an actual date.	
<u>Process for monitoring patients' health in relation to the use of medicines (including high risk medicines)</u> With the provider's permission, we undertook remote clinical records searches to identify specific cohorts of patients and then reviewed individual records identified by these searches. This highlighted concerns that the practice's monitoring systems did not always keep patients safe in relation to the use of medicines (including high risk medicines). Our clinical records searches identified two patients being prescribed Lithium - neither of whom were receiving regular monitoring in accordance with National Institute for Health and Care Excellence	

Medicines management	Y/N/Partial
<p>(NICE) recommendations. One patient had continued to be issued Lithium despite records showing the course of medication had ended. The other patient had been prescribed Lithium in June 2021 but in the absence of NICE recommended six-monthly Thyroid Function Test results.</p> <p>Our clinical records searches identified two of eleven patients prescribed Methotrexate were not receiving regular monitoring. One patient was being co-prescribed another medication which had a risk of blood toxicity but without appropriate action being taken to manage risks to the patient. The other patient had been prescribed Methotrexate in June 2021 but in the absence of NICE recommended three-monthly Liver Function Test results.</p> <p>Our clinical records searches highlighted that eleven of the fifteen patients being prescribed ACE or ARB & Spironolactone concomitantly had not been advised of the increased risk this presented regarding severe hyperkalemia, particularly in patients with marked renal impairment.</p> <p><u>Medical Oxygen and Defibrillator</u></p> <p>Although there was medical oxygen and a defibrillator on site, the practice was not acting in accordance with its own governance arrangements and undertaking periodic checks of this equipment.</p>	

Track record on safety and lessons learned and improvements made

The practice did not have a system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	N
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	N
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	N
Number of events recorded in last 12 months:	1
Number of events that required action:	1
Explanation of any answers and additional evidence:	
<p>When things went wrong, the approach to reviewing and investigating causes was insufficient. Before our inspection we asked for a log of significant incidents logged in the last 12 months. We were sent a combined spreadsheet of significant incidents and complaints which indicated that one significant incidents had been logged in the previous 12 months (regarding seven patients having been immunised prior to their scheduled date).</p> <p>However, minutes of clinical and non-clinical team meetings could not confirm that this incident had been discussed and so it was unclear how learning took place and what actions had been undertaken to improve safety.</p> <p>The minutes of a September 2020 clinical meeting confirmed that staff had discussed a patient death, but we noted this had not been logged as a significant incident and that significant incidents were not a standing agenda item. It was unclear how clinical meetings supported leaders in a structured manner in managing current and future risks.</p> <p>We also noted that non-clinical team meeting minutes did not contain standing agenda items to discuss learning from significant incidents. Although non-clinical staff members told us how they would report a significant incident, it was unclear where discussion and learning would take place (including on subsequent actions taken to improve safety).</p>	

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

Event	Specific action taken
Patients immunised prior to their scheduled date.	CQC advised of a verbal discussion with practice nurse and of a verbal discussion with administrative staff, advising them to book patients at the correct age.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	No
<p>Explanation of any answers and additional evidence:</p> <p>We found the provider lacked an effective system to ensure it acted on Medicines and Healthcare products Regulatory Agency (MHRA) patient safety alerts. We were told that the provider did not have its own protocol for disseminating and acting on alerts; and had adopted the local Primary Care Network's Safety Alert protocol.</p> <p>However, we received conflicting information from staff members regarding who was responsible for receiving and disseminating patient safety alerts. Consequently, a clinical records search highlighted that eleven of the fifteen patients being prescribed ACE or ARB & Spironolactone concomitantly had not been advised of the increased risk this presented regarding severe hyperkalaemia, particularly in patients with marked renal impairment. We were not assured there was appropriate clinical involvement and oversight regarding patient safety alerts.</p> <p>Shortly after our inspection we were advised that a practice specific alert protocol had been introduced.</p>	

Effective Improvement

Rating:

Requires

- We saw instances of where people did not receive effective care or treatment (for example, regarding missed annual asthma reviews).
- Although the practice had adopted a programme of quality improvement activity, we saw very limited evidence of learning and reflective practice.
- We could not be assured that induction arrangements supported new staff to be able to safely and effectively manage patients.

Effective needs assessment, care and treatment

Patients' needs were not assessed, and care and treatment were not 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.	No
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Although monthly clinical meetings took place, meeting minutes highlighted the absence of standard agenda items covering feedback on recent training, quality improvement activity and discussion of latest evidence-based guidance.</p> <p>Consequently, our remote clinical searches highlighted instances where care delivered did not reflect current evidence-based guidance. This included arrangements for monitoring high risk medicines.</p>	

Older people

Population group rating: Good

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.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed 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.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.
- Our remote clinical searches highlighted instances where people from this population group were not receiving effective care or treatment. For example, outstanding annual asthma reviews and sub optimal care being provided for patients with hypertension.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	72.7%	76.1%	76.6%	No statistical variation
PCA* rate (number of PCAs).	3.4% (6)	7.0%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	100.0%	89.5%	89.4%	Variation (positive)

PCA rate (number of PCAs).	15.2% (5)	7.9%	12.7%	N/A
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*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	80.0%	83.8%	82.0%	No statistical variation
PCA* rate (number of PCAs).	6.3% (3)	3.6%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	48.4%	65.9%	66.9%	Variation (negative)
PCA rate (number of PCAs).	10.4% (29)	10.2%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	63.0%	72.4%	72.4%	No statistical variation
PCA rate (number of PCAs).	4.4% (22)	5.3%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) (QOF)	100.0%	91.4%	91.8%	Variation (positive)
PCA rate (number of PCAs).	27.3% (6)	6.7%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	80.1%	78.8%	75.9%	No statistical variation
PCA rate (number of PCAs).	6.5% (18)	7.1%	10.4%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments

We discussed the practice's Personalised Care Adjustment rates with leaders and were advised that patient removal from an indicator only took place in specific circumstances and was overseen by a specific staff member.

Findings

- The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for the five childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- We saw evidence that people from this population group were not receiving effective care or treatment. For example, in 2020 an administrative error had resulted in seven patients having been immunised prior to their scheduled date. However, it was unclear how the practice's recall systems had since been amended, to improve patient safety.

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) (01/04/2019 to 31/03/2020) (NHS England)	39	48	81.3%	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) (01/04/2019 to 31/03/2020) (NHS England)	38	48	79.2%	Below 80% uptake
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) (01/04/2019 to 31/03/2020) (NHS England)	38	48	79.2%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	37	48	77.1%	Below 80% uptake
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	40	57	70.2%	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

Unverified 2020/21 practice data indicated:

- 1-year old child immunisation uptake=91%
- 2-year-old child immunisation uptake = 81%
- 5-year-old child immunisation uptake = 77%

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- 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.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 31/12/2020) (Public Health England)	66.4%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	57.6%	56.6%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	50.7%	52.7%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	100.0%	94.2%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	50.0%	56.9%	54.2%	No statistical variation

Any additional evidence or comments

Unverified practice data indicated that 81% of women eligible for cervical cancer screening were screened adequately (specified period: within 3.5 years for women aged 25 to 49).

Unverified practice data indicated that 86% of women eligible for cervical cancer screening were screened adequately (specified period: within 5.5 years for women aged 50 to 64).

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People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- Same day appointments and longer appointments were offered when required.
- End of life care was delivered in a coordinated way which considered 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.
- Our remote clinical searches highlighted instances where people from this population group were not receiving effective care or treatment. For example, our remote clinical search highlighted that annual health checks of patients with a learning disability contained a standardised health check summary statement. We therefore could not be assured that systems were in place to ensure the checks considered the full range of peoples' needs.

**People experiencing poor mental health
(including people with dementia)**

Population group rating: Requires Improvement

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Our remote clinical searches highlighted instances where people from this population group were not receiving effective care or treatment. For example, we saw evidence that patients being prescribed high risk medicines to treat mental health conditions had not received appropriate monitoring.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	100.0%	88.3%	85.4%	Variation (positive)
PCA* rate (number of PCAs).	2.6% (1)	7.6%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	81.8%	81.8%	81.4%	No statistical variation
PCA rate (number of PCAs).	15.4% (2)	4.7%	8.0%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments

Monitoring care and treatment

We saw evidence of a programme of quality improvement activity.

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	527	533.9
Overall QOF score (as a percentage of maximum)	94.3%	95.5%
Overall QOF PCA reporting (all domains)	5.4%	5.9%

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

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

We saw evidence the practice had undertaken two cycle clinical audits including an audit on the effect of Covid-19 pandemic on referral patterns, an audit of two week wait cancer referrals and an audit assessing whether increases in knowledge via training courses had led to a reduction in referrals.

However, the practice could not demonstrate that audit results had been discussed or learning shared at clinical meetings. We noted these meetings did not routinely discuss quality improvement activity and how this could be used to drive improvements in patient outcomes.

Any additional evidence or comments

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Partial
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.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: We noted that the list of induction activities signed as having been undertaken by a recently appointed non-clinical staff member differed from the mandatory induction activities listed in the practice's Induction Check List document. We also found that the practice's Induction Check List document was not dated or version controlled and so it was unclear whether the referenced practice protocols were current. In addition, the practice was unable to provide signed confirmation that two recently appointed clinicians had undergone a formal induction programme. We could not be assured induction arrangements enabled new staff to have access to accurate information, that enabled them to safely and effectively manage patients.	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

Explanation of any answers and additional evidence:

Helping patients to live healthier lives

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

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

Any additional evidence or comments

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.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: Leaders spoke positively about how staff strove to be courteous to patients; and to treat them with dignity and respect. We were told that staff spoke a number of local community languages including Spanish, Turkish, Portuguese, Ibo, Greek, Mandarin, Hundi and Gujurati.	

Source	Feedback

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 01/03/2021)	84.5%	88.2%	89.4%	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 (01/01/2021 to 01/03/2021)	84.8%	86.5%	88.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 01/03/2021)	97.9%	94.6%	95.6%	No statistical variation

Any additional evidence or comments

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

Any additional evidence

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: Patient information leaflets and notices were available in the patient waiting area which signposted patients support groups and organisations. Information about support groups was also available on the practice website. Easy read and pictorial materials were available in the reception area.	

Source	Feedback
-	-

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 01/03/2021)	89.6%	91.4%	92.9%	No statistical variation

Any additional evidence or comments

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

Carers	Narrative
Percentage and number of carers identified.	Less than 1%.
How the practice supported carers (including young carers).	Patients who were carers were flagged on the practice's computer system and prioritised for appointments where necessary. Written information was available to direct carers to the various avenues of support available to them.
How the practice supported recently bereaved patients.	Staff told us that following a bereavement, a GP contacted the bereaved family or sent them a sympathy card.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence:	

- Complaints were handled inappropriately and we did not see evidence of discussion, shared learning or how complaints led to improvements in the quality of care.
- The practice offered evening extended hours appointments until 7.30pm on Mondays and Tuesdays, for those who could attend during normal opening hours.
- Consequently, patient feedback was above local and national averages regarding appointments access. Patients fed back that they could access the right care at the right time.

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.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8:00hrs - 19:30hrs
Tuesday	8:00hrs - 19:30hrs
Wednesday	8:00hrs - 18:30hrs
Thursday	8:00hrs - 18:30hrs
Friday	8:00hrs - 18:30hrs

Appointments available:	
Monday	9:00hrs-12:00hrs &15:30hrs-18:00hrs
Tuesday	9:00hrs-12:00hrs &15:30hrs-18:00hrs
Wednesday	9:00hrs-12:00hrs &15:30hrs-18:00hrs
Thursday	9:00hrs-12:00hrs &15:30hrs-18:00hrs
Friday	9:00hrs-12:00hrs &15:30hrs-18:00hrs

Patients can book appointments to be seen at local hub centres between 18:30hrs-20:30hrs on weekdays or on weekends (Saturday and Sunday) 08:00hrs-20:00hrs.

Older people

Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> • Our review of complaints management indicated that complaints were not being used to make care more responsive for this population group. • All 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 provided effective care coordination to enable older patients to access appropriate services. • In recognition of the religious and cultural observances of some patients, GPs would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred. We saw evidence that revised local protocols in this regard had been discussed at clinical meetings. • There was a medicines delivery service for housebound patients.

People with long-term conditions

Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> • Our review of complaints management indicated that complaints were not being used to make care more responsive for this population group. • Patients with multiple conditions had their needs reviewed in one appointment. • The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services. • The practice liaised regularly with the local district nursing team to discuss and manage the needs of patients with complex medical issues. • Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Requires Improvement

Findings

- Our review of complaints management indicated that complaints were not being used to make care more responsive for this population group.
- Additional nurse appointments were available until 7.30pm on Mondays and Tuesdays for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- Our review of complaints management indicated that complaints were not being used to make care more responsive for this population group.
- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 7:30pm on Monday and Tuesday evenings. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a local GP federation. Appointments were also available at weekends (8:00am – 8:00pm).

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- Our review of complaints management indicated that complaints were not being used to make care more responsive for this population group.
- The practice held a register of patients living in vulnerable circumstances including 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 provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including g people with dementia)

Population group rating: Requires Improvement

Findings

- Our review of complaints management indicated that complaints were not being used to make care more responsive for this population group.
- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Access to the service

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

National GP Survey results

	Y/N/Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Patients were able to make appointments in a way which met their needs.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
There were systems in place to support patients who face communication barriers to access treatment.	Y
Patients with urgent needs had their care prioritised.	Y
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Y
Explanation of any answers and additional evidence:	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 01/03/2021)	77.0%	N/A	67.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 01/03/2021)	73.9%	66.3%	67.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2021 to 01/03/2021)	74.1%	73.8%	75.2%	No statistical variation

Any additional evidence or comments

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Source	Feedback
National GP Survey Results (2021)	<ul style="list-style-type: none"> • 79% of respondents described their experience of making an appointment as good (compared to 69% local CCG and 71% national averages). • 81% of respondent were offered a choice of appointment when they last tried to make an appointment (compared to 68% local CCG and 69% national averages).

Listening and learning from concerns and complaints

Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	5
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	0
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	N
<p>Explanation of any answers and additional evidence:</p> <p>Complaints were handled inappropriately and we did not see evidence of discussion, shared learning or of how complaints led to improvements in the quality of care.</p> <p>We reviewed two complaints contained in the practice's complaints folder. We found that one complaint had not been acknowledged or investigated and that a handwritten note on the other advised that staff had contacted the patient. This complaint had also not been acknowledged.</p> <p>Leaders told us that the practice manager contacted patients immediately following receipt of a complaint to seek a resolution. However, we did not see evidence that complaints were subsequently discussed at a team meeting or that learning was used to improve the service.</p> <p>Shortly after our inspection we were advised that the practice's complaints management system had been revised, so as to ensure that complaints were used as an opportunity to learn.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
-	-

Well-led

Rating: Inadequate

- Governance failures hindered the delivery of high-quality care (for example, failures regarding adherence to emergency medicines protocols, recruitment checks and staff induction).
- We noted limited systems for identifying and managing risks and consequently saw examples of where risks had not been identified or acted upon (for example lapsed staff training and missing pre employment checks).
- We also saw instances where leaders appeared to be out of touch with what was happening during day-to-day services (for example, an absence of clinical oversight for safety alerts and an absence of administrative oversight for complaints management).
- Although we saw evidence of quality improvement activity, there was minimal evidence of shared learning or reflective practice.
- The delivery of high-quality care was not assured by the leadership, governance or culture in place.

Leadership capacity and capability

We looked at whether leaders demonstrated that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
We saw evidence that leaders understood and had acted on the challenges to quality and sustainability presented by the Covid-19 pandemic. For example, we saw evidence of discussion of Covid-19 guidance at clinical meetings and that patient interaction arrangements and physical layout had been revised.	
However, we also saw instances where leaders appeared to be out of touch with what was happening during day-to-day services. For example, regarding clinical oversight of safety alerts and administrative oversight of complaints.	

Vision and strategy

The practice had a clear vision, but it was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial
There was a realistic strategy to achieve their priorities.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	N
Explanation of any answers and additional evidence: Although staff had a clear and shared vision to ensure that 'every patient mattered'; this was not underpinned by a credible strategy. Failures to act in accordance with the practice's governance arrangements had also hindered the delivery of high-quality care (for example regarding emergency medicines protocols, complaints management and staff induction/recruitment arrangements).	

Culture

The practice culture did not effectively support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	N
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We did not see evidence that when people when things went wrong, complainants were given an apology and informed of any resulting action.</p> <p>Leaders displayed candour and openness and honesty when explaining the practice's governance arrangements and when acting on our requests for additional information.</p>	

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

Source	Feedback
Group discussion with three non-clinical staff members	Spoke positively about working at the practice and about practice leadership.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	N
Explanation of any answers and additional evidence: Governance arrangements did not work effectively and placed patients at risk. Staff failed to work in accordance with the emergency medicines protocol (for example by failing to undertake periodic checks of emergency oxygen and defibrillator). Also, some protocols (for example Fire Safety) were not version controlled and so it was unclear if staff were working to current protocols. An absence of a practice specific protocol for safety alerts created confusion regarding roles and responsibilities, such that some alerts had not been sufficiently acted upon. This placed patients at risk.	

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	Partial
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
Explanation of any answers and additional evidence: We saw limited evidence of effective arrangements for identifying, managing and mitigating risks. Although regular clinical and non-clinical team meetings took place, these did not discuss current and emerging risks. Consequently, we identified several instances where risks had not been managed (for example regarding lapsed staff training, an absence of pre employment checks and a failure to act on safety alerts).	

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
Team meeting minutes evidenced periodic use of data to monitor and improve performance; and use of performance information to hold staff to account.	
We saw limited evidence of effective arrangements for identifying, managing and mitigating risks.	

Governance and oversight of remote services

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

Engagement with patients, the public, staff and external partners

The practice involved involve 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.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: We were advised that the practice's Patient Participation Group was active and held remote meetings. We noted that the practice was part of a Primary Care Network of local practices and as such worked with these practices to build a shared view of challenges and of the needs of the population.	

Feedback from Patient Participation Group.

Feedback
-

Any additional evidence

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Continuous improvement and innovation

We saw evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	N
Explanation of any answers and additional evidence: We saw evidence the practice had undertaken two cycle clinical audits including an audit on the effect of Covid-19 pandemic on referral patterns, an audit of two week wait cancer referrals and an audit assessing whether increases in knowledge via training courses had led to a reduction in referrals.	

Examples of continuous learning and improvement

Although the practice had undertaken several two cycle clinical audits in the previous 24 months, we did not see evidence that audit results were discussed at clinical meetings, formed part of reflective practice or were used to drive improvements in patient outcomes.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

- COPD:** Chronic Obstructive Pulmonary Disease.
- PHE:** Public Health England.
- 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.
- *PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- ‰ = per thousand.