

Care Quality Commission

Inspection Evidence Table

Yellow Practice (1-5350568122)

Inspection date: 27-30 June 2022

Date of data download: 08 June 2022

Overall rating: Requires Improvement

At our previous inspection in October 2021, we rated the provider as Requires Improvement overall. This was because we found breaches of regulation in the Safe, Effective and Well-led domains.

At this inspection we found the practice had made improvements. For example, Patient Group Directions were appropriately signed by the nurses and had an authorising signature; fridge temperatures were being monitored and staff knew what to do if a temperature went out of the required range. We saw evidence of second cycle audits and policies contained up to date information. However, some policies lacked clarity and the practice had adopted a different approach to what was stated in the policy. A recruitment file we reviewed did not contain the required information and clinical rooms used by practice staff were not always checked to ensure patient safety.

Safe

Rating: Requires Improvement

At the previous inspection the practice was rated as Requires Improvement for the Safe domain because:

- The monitoring of fridge temperatures failed to ensure the safe storage of medicines.
- The security of blank prescription forms was not in line with current guidance.
- Patient group directions were signed incorrectly.
- There was a lack of monitoring of staff immunisations.
- Infection prevention control audits were invalid as staff lacked the knowledge and understanding to accurately complete them.
- The practice had failed to assess the risks associated with the Control of Substances Hazardous to Health (COSHH);
- Significant event reporting processes were not clearly understood or implemented.
- Processes for identifying and managing risks were not always clear or working as intended.

At this inspection we found:

- Fridge temperatures were being monitored and information was recorded in both a written format and on the practice computer system, which could be easily monitored for compliance.
- Blank security forms were stored securely and were being tracked.
- Patient Group Directions were signed by the nurses and were authorised by the lead GP.
- We noted that infection control audits had been completed by the lead GP and quarterly checks were taking place. Any action required was recorded and monitored. However, we noted the

provider had not recognised an infection control risk to their patients and staff members when using a shared room with the other two practices within the building. For example, the sharps bins in a shared room had been in use for longer than the recommended three months and the disposable curtain was last changed in August 2021, which is longer than the recommended time frame of six months.

- The practice was going through a large renovation of the building. We noted that a layer of dust was found on some of the low level equipment in clinical rooms. The cleaning cupboard was not available to practice staff as the landlords cleaning staff were the only people able to access it.
- Staff immunisation was recorded and included in the recruitment files. However, the policy lacked consistency when referring to the title of roles within the practice.
- The practice had risk assessed all products required for COSHH. We saw data sheets and specific risk assessments completed.
- Staff we spoke with were aware of how to report a significant event and we saw these were recorded on the practice computer system, discussed at weekly team meetings and shared with all team members for wider learning.
- A recruitment file we reviewed did not contain the required information (although some of the missing information was sent after the onsite visit). The practice was not working to its own policy of recording the required information.

Safety systems and processes

The practice had some systems, practices and processes to keep people safe and safeguarded from abuse. Recruitment of new employees and DBS checks needed to be improved.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	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.	P
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: We reviewed three recruitment files for newly appointed staff members. We found that for one member of staff there was a DBS check on file but this was from their last employer and dated from 2019. DBS checks are not transferable (unless the applicant has signed up to this service). A DBS check has no official expiry date but the information included will only be accurate at the time the check was carried out. After the inspection the practice sent us evidence that a new DBS check had been requested.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection we found:</p> <p>Three staff members, recruited within the last 12 months, whose recruitment files did not contain the required information. There were no interview summaries available for all three staff members and no employment history for one. We found that one reference had been obtained for two of the staff members. There were no references available for the third member of staff. We noted that this was in contradiction with the practice's safeguarding policy which stated that two references should be obtained for all newly recruited staff.</p> <p>We reviewed individual staff immunisation records related to four staff members and found that they were not in line with current guidance. The practice had not made any assessment of the risk of staff members fulfilling their roles where immunisation status had not been confirmed.</p> <p>At this inspection:</p> <p>We reviewed three newly recruited staff members recruitment files. Two contained the required information. However, one file did not contain a full CV or application, a full employment history, references from past employers, or a DBS check. We brought this to the attention of the provider and the day after the onsite inspection they were able to send us some of the missing documents. However, the CV for the new recruit did not contain the names of their most recent previous employers. Although the leaders of the practice, were aware of where the staff members last employment had been, this was not evidenced in their file or in the additional information sent.</p> <p>We saw evidence that staff immunisation was recorded. However, the policy lacked clarity in terms of which roles required which immunisations. The policy contained an immunisation matrix which we saw on new starters' recruitment files. However, the policy lacked consistency when referring to the title of roles within the practice.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: January 2022	Y
There was a fire procedure. Date of fire risk assessment: October 2021	Y
Actions from fire risk assessment were identified and completed.	P
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection we found:</p> <p>An external health and safety evaluation of the premises had been undertaken. The resulting report highlighted a number of concerns. This included a lack of information from the landlord relating to the servicing of emergency lighting and fire alarm testing records.</p> <p>At this inspection we found:</p>	

The building the practice was situated in was in the process of being refurbished by the landlord. Building work included the creation of a purpose built immunisation room, reconfiguration of existing rooms and the creation of new rooms to provide clinical, consulting and operational rooms. Electrical, plumbing and data re-wiring was also being completed to modernise the existing infrastructure. We saw that the building company had supplied a construction phase plan and a limited risk assessment for the building work taking place.

We saw that the landlord had provided evidence of monthly emergency lighting checks up until February 2022. The practice was still waiting for the most recent fire alarm tests from the landlord but had received documentation of checks being completed up until October 2021. The practice was able to send us copies of emails chasing for this information which the landlord had yet to provide.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not always met.

	Y/N/Partial
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: December 2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	P
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection we found:</p> <p>The practice had conducted an infection control environmental audit dated 20 September 2021. It was noted that some findings had not been identified or actioned. For example, staff immunisation had been recorded as completed but staff records showed gaps in immunisation. The audit failed to recognise concerns raised from a fly infestation and or that a three stage decontamination process for instruments did not apply to the practice.</p> <p>At this inspection we found:</p> <p>The practice had completed a further infection control audit in December 2021. The areas highlighted at our previous inspection had been corrected. The audit highlighted other actions required which we saw had been recorded and most were complete. However, we noted infection control risks within a room shared with the other two practices within the building. The provider has a responsibility to ensure they are preventing, detecting and controlling, infection control risks to their staff members and patients. We saw that the room contained sharp bins which had been in use for longer than the recommended three months and the disposable curtain was last changed in August 2021, which is longer than the recommended time frame of six months. These issues had not been recognised by the practice.</p> <p>We also saw there was low level dust and dirt on some equipment used by the practice in two clinical rooms. We spoke with the leaders in regard to this. Staff cleaned equipment in between patients and at the end of the day. However, there was no recording of this or the equipment needing to be cleaned. The building was currently undergoing a major refurbishment and the practice was unable to access the cleaning cupboard but instead informed the landlord and the cleaning company of any issues. This</p>	

meant there could be a delay if additional cleaning was required while the building work continued and cleaning staff were not present. We noted that a number of concerns had been flagged to the landlord for actioning. Following our inspection, the practice told us they had contacted the external cleaning company whose role it is to clean the desk, chair and bed in clinical rooms to ensure adequate cleaning was completed.

Risks to patients

There were some 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.	P
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection we found: The practice had experienced a high turnover of staff at all levels which had led to disruption and challenges for the team. The practice utilised the services of a locum GP and a locum practice nurse who provided regular sessions. Recruitment of a permanent GP and a practice nurse was planned for forthcoming months.</p> <p>At this inspection we found: The practice had employed a number of new staff members, including, administration staff, a part time GP, locum GPs, locum nurses and a healthcare assistant. We reviewed inductions for new staff members. We noted that there were no role-specific induction records available. We noted that the current practice nurse was soon to retire. Leaders told us that they were still in the process of recruiting new staff.</p>	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y

There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection we found: 24 patients with hypothyroidism who may not have had thyroid function test monitoring within the last 18 months. We reviewed the records of five of those patients and found that monitoring was overdue.</p> <p>At this inspection we found: Four patients with hypothyroidism who may not have had thyroid function test monitoring within the last 18 months. We reviewed the records of all of those four patients and found that monitoring had been completed as required, either through the hospital or privately and the results were recorded on the patient record.</p>	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.68	0.71	0.79	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	8.4%	10.3%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary	5.88	5.90	5.29	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
tract infection (01/10/2021 to 31/03/2022) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	129.7‰	76.2‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.70	0.71	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	6.6‰	5.4‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	n/a
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y

Medicines management	Y/N/Partial
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.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	N
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection we found:</p> <p>The security and tracking of blank prescription forms was not maintained in line with current guidance.</p> <p>Patient Group Directions (PGDs) had been incorrectly completed and did not ensure the safe administration of those medicines to the selected patients.</p> <p>Medicines requiring refrigeration were stored within three lockable fridges. Two of the fridges were overstocked, with medicines packed tightly together and against the inside of the fridges. Temperature monitoring records showed that fridges had exceeded the recommended maximum temperature of eight degrees centigrade. No action had been taken to ensure the safety of medicines stored within the fridge or to provide a reason for the high temperatures.</p> <p>At this inspection we found:</p> <p>Blank prescription forms were tracked and recorded. We saw evidence of prescription form serial numbers being recorded in order to demonstrate their secure distribution and use within the practice. Prescriptions forms were held securely and could only be accessed by authorised staff members.</p> <p>PGDs were signed by specified staff members to confirm their understanding of administering the medicine. The same PGDs were then signed by the authorising GP to verify the competence of the specified staff.</p> <p>At the time of the inspection only one of the medicine fridges was being used to store medicines. This was stocked appropriately, with space between the individual vaccines and away from the side of the fridge walls. The recording of fridge temperatures showed these were all within range. We saw there was a new procedure for recording temperatures. Staff recorded the actual temperature, the minimum and maximum and then reset the temperature ready for the next recording. These temperatures were then recorded on to the practice computer system which was monitored. This meant that if the temperature was not recorded or had gone out of range it would be clearly recognised and action taken. We noted that the temperature for the two fridges not in use, did not differ much in their temperature ranges. We saw that these fridges had been calibrated and an engineer called to check they were working correctly. There had been no concerns raised at either of these checks.</p> <p>We reviewed the emergency equipment shared by the three practices, as well as those specifically for Yellow Practice. We reviewed Yellow Practice's weekly emergency medicines checklist. We found that the oxygen, defibrillator, and pulse oximeter had last been recorded as being checked on the 19 April 2022. We noted that two masks required for the administration of emergency oxygen were out of date. An adult mask held an expiry date of April 2021 and a child mask February 2021. The oxygen was shared by all three practices and checked weekly, but these had not been identified as out of date.</p>	

Medicines management	Y/N/Partial
Whilst reviewing Yellow Practice's emergency equipment we noted three adult nebuliser masks were out of date. We also found there was no paediatric pulse oximeter available. We brought this to the attention of the leaders who ordered these whilst we were present.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	11
Number of events that required action:	11
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection we found: Staff we spoke with were unclear on what constituted a reportable incident. Staff described additional events which had not been recorded. We saw recorded two significant events in the last 12 months</p> <p>At this inspection we found: The practice had recorded 11 significant events since our last inspection. Staff we spoke with told us they were confident in raising any significant events and were aware of the process to follow. We saw these were discussed during staff meetings and actions were clearly recorded.</p>	

Example of significant events recorded and actions by the practice.

Event	Specific action taken
Unlabeled bottle to provide urine sample given to patient. Subsequently not processed by laboratory	Staff to ensure that all bottles are labelled and correct red top bottle used Flow chart to be added to front desk

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw examples of actions taken on recent alerts. We also saw evidence of alerts being discussed at weekly meetings.</p>	

Effective

Rating: Good

At the previous inspection the practice was rated as Requires Improvement for the Effective domain because:

- There was limited evidence of quality improvement activity.
- Reviews at the end of probationary periods for new staff were not always carried out in a timely manner.

At this inspection we found:

- The practice had recorded a variety of audits. This included two cycle audits and audits to improve quality.
- Staff had received an appraisal and staff at the end of the probation had received a review. However, new staff members had not received job specific inductions.

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

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- 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.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- 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.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances, including homeless people, travelers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- 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.

Management of people with long term conditions

Findings

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	43	47	91.5%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	69	78	88.5%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	68	78	87.2%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	69	78	88.5%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	43	60	72%	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 childhood immunisation data is impacted by the low number of eligible children registered at the practice. However, we noted that figures were higher than at the last inspection. For example, previously 81.3% of children aged two had received their booster immunisation for Pneumococcal infection. 81.3% of children aged two had received their immunisation for Hib and MenC and 79.2% of children aged two had received immunisation for MMR.

The practice had conducted an audit of those children still requiring their immunisation and staff were contacting parents or guardians.

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.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	72.1%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	60.2%	62.1%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	63.3%	69.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	48.0%	56.7%	55.4%	No statistical variation

Any additional evidence or comments

We spoke with the practice in regard to their cervical screening figures. They told us cervical screening clinics were held, as well as providing ad hoc cervical screening appointments. The practice contacted eligible patients for cervical screening via a letter and a phone call to influence patients to attend their appointments. Non-attenders were flagged on the patient's record so that the screening test could be discussed opportunistically.

Monitoring care and treatment

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

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

At our previous inspection we found:

Evidence of three clinical audits but these were single cycle audits to review monitoring compliance rather than to drive quality improvement. The lead GP told us that additional clinical audits had been undertaken but not written up. For example, they told us had undertaken an audit to monitor the prescribing of an antidepressant medicine, Citalopram. However, our searches of the practice's clinical records system identified two patients over the age of 65 years who were prescribed Citalopram which exceeded the maximum recommended dosage.

At this inspection we found:

Evidence of audits, including second cycle audits which were used to improve quality. For example, two cycle audits for patients with severe frailty, patients prescribed blood thinning medicines, patients prescribed medicines for heart rhythm problems and an audit for safeguarding registers.

We noted that there were no patients prescribed Citalopram which exceeded the maximum recommended dosage.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. However, job specific inductions were not available for staff.

	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.	P
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.	n/a
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:

At our previous inspection we found:

Staff told us they had not recently received an appraisal or formal review of their performance. Staff who had recently completed their probationary period had not undergone a probationary review, and they told us that this meant they had not been confirmed in their post.

Locum staff employed on a regular basis told us they did not participate in any review of their performance within the practice.

At this inspection we found:

Staff had received a recent appraisal, including locum staff. Staff we spoke with told us they found this useful. We saw evidence of appraisals on staff files. Newly recruited staff that were outside of their probation period had received a review. However, we noted that new staff had not received a job specific induction and so we could not be assured that probational reviews covered all of the areas that staff were required to work.

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

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

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

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

Patient feedback	
Source	Feedback
Friends and family test	91% of people who responded to the friends and family test between 15/06/2021 and 16/06/2022 said they would recommend the practice to their friends or family.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	88.4%	91.4%	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 31/03/2021)	83.1%	90.1%	88.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	92.9%	97.3%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	71.1%	86.0%	83.0%	No statistical variation

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y
<p>The practice had conducted a survey in relation to their telephone system. In response to feedback they had made the following changes:</p> <ul style="list-style-type: none"> • Changed the phone message to direct patients more clearly to specific options. For example, appointments, results and prescriptions and advise for other services such as LIVI, 111 and online access. • New team recruited and allocated to each phone line, helping to ease access to the phone lines. • Website changed to show patients all services that were available • High risk patients such as palliative care, carers, extremes of age were highlighted allowing them faster access. • Calls were recorded to aid in any complaints process • Recruitment of two part time GPs, a part time nurse and a new pharmacist to help increase appointment capacity. 	

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

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	91.6%	95.2%	92.9%	No statistical variation

	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

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 99 patients who were carers (2% of practice population)
How the practice supported carers (including young carers).	The practice provided signposting information to carers support groups and offered flu vaccinations.
How the practice supported recently bereaved patients.	The practice offered support to bereaved patients.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	P
<p>Explanation of any answers and additional evidence:</p> <p>The reception desk was in an area shared by two other GP practices. The practice had installed screens within the administration area, and where possible calls were taken away from the reception desk, to help with privacy. During our onsite inspection we noted a patient being given a pen and paper to write down confidential information. Patients were also requested to stand back from the counter until it was their turn to speak to the receptionists.</p>	

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.	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

Practice Opening Times	Practice Opening Times	Appointments available:
Monday	8am – 6.30pm	9am - 3pm - 4.30pm – 5.30pm
Tuesday	7.30am – 6.30pm	9am - 3pm - 4.30pm – 5.30pm
Wednesday	7.30am – 6.30pm	9am - 3pm - 4.30pm – 5.30pm
Thursday	8am – 6.30pm	9am - 3pm - 4.30pm – 5.30pm
Friday	7.30am – 6.30pm	9am - 3pm - 4.30pm – 5.30pm
The practice was part of a federation of GP practices that offer evening appointments and weekend appointments. Patients were able to access NHS GPs via video through a smartphone app. When the surgery was closed patients were advised to contact NHS 111.		

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

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.

All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers.

The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection we received patient comments in relation to the phone system and booking of appointments. The practice had reviewed comments from friends and family feedback, patient survey data, survey monkey, and the Patient Participation Group. In response, calls were now answered within a three ring specified time frame and staff gave patients a window of time for when a clinician would call them back. The practice had also shortened the message on the phone line, and instead of silence while waiting for the call to be answered when queuing, music was played instead.</p> <p>The practice website was up-to-date and included information about how to book an appointment, what to do in an emergency or when the practice was closed. The website included information about a range of local community-based services and services to which patients could self-refer.</p>	

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	45.2%	N/A	67.6%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the	48.2%	73.6%	70.6%	Tending towards

Indicator	Practice	CCG average	England average	England comparison
overall experience of making an appointment (01/01/2021 to 31/03/2021)				variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	48.6%	67.5%	67.0%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	71.2%	83.3%	81.7%	No statistical variation

Any additional evidence or comments

Due to the frequency of patient survey updates the results above remained the same as at the previous inspection.

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.	6
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	1

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

Well-led

Rating: Requires Improvement

At our previous inspection we found:

- Insufficient improvement had been made to address the breaches of regulation identified within our previous inspection.
- Leaders were unable to demonstrate that governance processes, risk management, performance, and strategic planning ensured high quality and sustainable care.
- Processes for identifying and managing risk were not always clear or working as intended.
- Leaders had insufficient oversight in order to identify when processes were not working as intended.
- Organisational policies did not always contain accurate or up to date information to ensure appropriate guidance for staff.
- Staff had not recently undergone appraisal or interim performance review.
- Significant event reporting processes were not clearly understood or implemented.
- Premises were poorly maintained and deteriorating, and some areas were not fit for purpose.
- Recruitment records were incomplete and did not ensure the safe recruitment of staff.
- There was limited evidence of quality improvement activity.

At this inspection we found:

- The practice has made significant improvement and addressed most of the concerns raised.
- Governance processes demonstrated that the practice ensured high quality and sustainable patient care.
- Some processes for identifying and managing risk were still not clear or working as intended. However, leaders were aware of this and required further time for those processes to be improved or embedded further.
- Organisational policies had been reviewed and updated. However, the immunisation policy lacked consistency when referring to the title of roles within the practice.
- Staff had received appraisals and new staff members had received interim performance reviews. However, job specific inductions were not available.
- Staff felt confident to raise significant events and we saw evidence that these were regularly discussed with the team.
- The building was undergoing a major refurbishment.
- The system for recording the information required for recruitment records had been improved. However, one recruitment record we reviewed was incomplete and did not ensure the safe recruitment of staff.
- There was evidence of quality improvement activity and we saw evidence of a variety of audits completed.

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.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y

Explanation of any answers and additional evidence:

At our previous inspection we found:

Insufficient improvement had been made to address the breach of regulation previously identified and new breaches of regulation had been found.

Leaders lacked oversight of some processes and failed to identify risks when those processes did not operate as intended.

Leaders lacked the knowledge and capacity to ensure the implementation of processes. For example, there was a lack of understanding with regard to PGDs and staff immunisation.

There was not a clear succession plan in place for clinical or administrative leadership roles.

At this inspection we found:

Leaders of the practice had recognised the actions required to improve from the last inspections. We saw evidence of the commitment and work completed to address the breaches of regulation.

Leaders had worked hard to understand the processes and actions required around the breaches raised at the last inspections. However, some of these processes required further embedding or review to ensure they were working as intended.

We reviewed the practice's development plan dated April 2022 and updated June 2022. We saw included in the plan was staffing, which including planning for an additional GP partner and further staff members, to ensure that workforce capacity met the clinical commissioning group average. For example, the practice had employed a locum GP with plans to increase the number of sessions they worked and with the potential of becoming a future partner.

Vision and strategy

The practice had a clear vision, that was partially supported by a strategy to provide high quality sustainable care.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	P

Explanation of any answers and additional evidence:

At our previous inspection we found:

There was high levels of staff turnover, which presented recruitment challenges. The premises were poorly maintained. There was a basic practice development plan which did not constitute a credible strategy. It contained no timelines or progress monitoring.

At this inspection we found:

The practice was working with a full administration team and had employed a part time GP, a locum GP, and a locum nurse. We saw that the practice development plan dated June 2022 showed start dates or dates for completion. For example, full implementation of the practice's electronic management system by January 2023, pharmacist sessions to be confirmed and made regular through the Primary Care Network by August 2022, new staff to be fully trained by August 2022. However, progress against the practices' development plan or a record of the actions required was not included.

Therefore, it was difficult to ascertain in some areas how the plan was to be achieved and if sufficient progress was being made.

The practice premises were owned by a third party who were responsible for health and safety monitoring, maintenance and renovation. At the time of our inspection we saw that the renovation of the building had started. Building work would include the creation of a purpose built immunisation room, reconfiguration of existing rooms and the creation of new rooms to provide clinical, consulting and operational rooms. Electrical, plumbing and data re-wiring was also being completed to modernise the existing infrastructure. We saw that the building company had supplied a construction phase plan and a risk assessment for the building work taking place. However, the building work was included as a single entry in the practice development plan. There were no clear dates as to when the different elements would be achieved and the impact on the practice and its staff.

Culture

The practice had a culture which drove high quality sustainable.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. However, some of these areas still needed to be improved or fully embedded to ensure they were working as intended.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	P
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence: At our previous inspection we found:</p> <p>Some governance arrangements were not being implemented effectively partially due to the lack of understanding and knowledge of leaders. For example, in the implementation of a staff vaccination programme and the governance of Patient Group Directions. In some areas, processes had not been established at all due to a lack of awareness by leaders. For example, there were no documented</p>	

processes or risk assessments to provide guidance for staff in the control of substances hazardous to health (COSHH).

The practice was not following its own policies. For example, the safeguarding policy stated staff were required to have two references as part of their recruitment check. However, the practice had not received two references for all staff.

At this inspection we found:

Leaders had recognised their lack of understanding in some areas and had worked hard to create a greater awareness where concerns had been raised. However, some of these areas still needed to be improved or fully embedded to ensure they were working as intended.

Staff recruitment files had been updated and an index sheet created so that information required could be cross checked. However, one file we reviewed for a new starter did not include the required documents (some documents were sent after the onsite inspection). The process needed to be further reviewed and embedded to ensure all staff had the required checks completed before starting their role.

The practice had risk assessments and guidance for staff for COSHH, and PGDs were signed correctly.

Managing risks, issues and performance

The practice did not always 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.	P
There were processes to manage performance.	Y
There was a quality improvement programme in place.	P
There were effective arrangements for identifying, managing and mitigating risks.	P
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.	P

Explanation of any answers and additional evidence:

At our previous inspection we found:

Risks were not consistently identified or managed. Leaders failed to identify risks when processes were not operating as intended. For example,

- The monitoring of fridge temperatures continued to fail to ensure the safe storage of medicines.
- The security of blank prescription forms was still not in line with current guidance.
- Patient group directions continued to be signed incorrectly.
- There was a lack of monitoring of staff immunisations.
- Infection prevention control audits were invalid as staff lacked the knowledge and understanding to accurately complete them.
- Recruitment records were incomplete and did not ensure the safe recruitment of staff.
- The practice had failed to assess the risks associated with the Control of Substances Hazardous to Health (COSHH). Leaders lacked an understanding of the requirements of COSHH.

- Significant event reporting processes were not clearly understood or implemented.
- Policies and procedures did not always contain accurate or up to date information to assure leaders that staff had the guidance they required to fulfill their roles.
- The premises within which the practice was located was owned by a third party who was responsible for the upkeep and maintenance. Health and safety and environmental monitoring and risk assessments were carried out by the third party but there were repeated long delays before the practice received copies of these. Therefore the practice was unable to assure itself that mitigating actions identified by the risk assessment were completed in a timely manner.
- The practice premises were poorly maintained and deteriorating, and some areas were not fit for purpose. Risks and health and safety concerns associated with the fabric of the building had been highlighted within a recent fire risk assessment and also a recent health and safety evaluation of the premises undertaken by an external advisor employed by the practice. For example, the 'daisy chaining' of extension leads. Staff described challenges in maintaining suitable premises due to events which were out of their direct control but had been raised with the landlord. For example, significant recurrent water leaks in the roof areas above the patient record storage cupboards and the consumable storage room. Staff told us they had to store all the consumables in plastic boxes to prevent water damage and that they placed buckets on top of the patient records filing cupboards when it rained to catch water leaking in through the roof. On the day of inspection we observed flies coming out of the sinks in three clinical rooms. Staff told us this was an ongoing problem in all of the rooms with sinks.

At this inspection we found:

- The monitoring of fridge temperatures ensured the safe storage of medicines.
- The security of blank prescription forms was in line with current guidance.
- Patient group directions were signed correctly.
- Staff immunisations were being monitored and recorded.
- Infection prevention control audits were completed with actions recorded. However, we noted the provider had not recognised an infection control risk to their patients and staff members when using a shared room with the other two practices within the building.. We also found low level dust on equipment, in two clinical rooms. There was no recording of the equipment needing to be cleaned in each room.
- Recruitment records had been reviewed and updated. However, we found one file which was incomplete.
- The practice had assessed the risks associated with the Control of Substances Hazardous to Health (COSHH).
- Significant event reporting processes was understood and we saw evidence of discussions had within staff meetings.
- Policies and procedures had been reviewed and those we reviewed contained accurate and up to date information. However, the immunisation policy lacked consistency when referring to the title of roles within the practice.
- Leaders demonstrated their continued attempts to contact the landlord to request required documents with regard to health and safety and environmental monitoring, and risk assessments. We noted that after the last inspection the landlord had sent evidence of monthly emergency lighting checks up until February 2022 and documentation of fire alarm tests being completed up until October 2021.
- The building the practice was situated in was going through a major refurbishment. We noted that building work was limited to weekends and evenings to minimise disruption. The practice was waiting for most of their rooms to be refurbished but was able to use one refurbished room

being used to store their consumables. The roof had been fixed and no longer leaked and the landlord had taken action in relation to the fly infestation.

- Electrical rewiring and plumbing was also part of the refurbishment and the practice had planned a health and safety review in October 2022.

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

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection we found:</p> <ul style="list-style-type: none"> • Staff told us they had not recently received an appraisal or formal review of their performance. • Newly recruited staff had not undergone a probationary review. • Locum staff employed on a regular basis told us they did not participate in any review of their performance within the practice. • The provider had failed to submit a statutory notification to the Care Quality Commission with regard to this incident, as required with all incidents reported to or investigated by the police. <p>At this inspection we found:</p>	

- Staff who had been at the practice for over 12 months had received an annual appraisal.
- Newly recruited staff had received a probationary review. However, job role specific inductions were not included for new staff and so we could not be assured that probation reviews covered all of the areas that staff were required to complete.
- We saw evidence of appraisals for locum staff.
- There had been no other incidents where the provider had needed to submit a statutory notification.

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.	Y
The practice had an active Patient Participation Group (PPG).	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
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection:</p> <ul style="list-style-type: none"> • Staff interaction with the PPG was limited due to COVID-19 restrictions • There was limited evidence that the service was acting on patient views. • Feedback received from patients showed that they experienced difficulties accessing the practice by telephone. <p>At this inspection we found:</p> <ul style="list-style-type: none"> • PPG meetings were held every eight weeks. The PPG told us meetings always included the Practice Manager and when possible the lead GP, as well as a representative of the reception/office team. • The practice had conducted several surveys and was using patient feedback in order to shape the practice. The PPG informed us that they felt their views were listened to and where possible acted upon. • Feedback from patients in relation to accessing appointments had been taken on board. A number of changes had happened in order to provide a better service for patients. 	

Feedback from Patient Participation Group.

Feedback
We received feedback from two members of the Patient Participation Group (PPG) who told us, the practice was very open and honest. They felt that information was shared and the practice had learned from past complaints & incidents. They told us they felt that the PPG was considered to be a very important part of the practice.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had worked hard to address the breaches found at the last inspection. There was a strong emphasis on learning from past mistakes and ensuring patients received the best care. Some of the actions taken needed to be further embedded or reviewed to ensure they were working as intended.</p> <p>The practice had made significant changes to the way calls were answered to improve access.</p> <p>The practice had engaged with a project which allowed patients to use an app at home to complete urinary checks to help identify kidney disease to improve renal health (Healthy IO).</p> <p>The practice and the PPG told us of future events happening at the practice. These included:</p> <ul style="list-style-type: none"> Utilising a discretionary taxi service for patients who do not have means for transport and would otherwise miss essential blood tests or appointments. Engaging with a local sensory awareness charity who will host a sensory awareness afternoon. 	

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:	Z-score threshold
Variation Bands	
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: [f](#)

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.