

Inspection Evidence Table

Hurley Clinic

(1-551713715)

Inspection Date: 13 and 14 September 2023

Date of data download: 31/07/2023

Overall rating: Requires Improvement

We have rated the practice as Requires Improvement overall because:

- The provider had not acted to address risks identified in legionella risk assessments.
- Staff did not always have the appropriate authorisations to administer medicines via the correct use of Patient Group Directions.
- All medicines were not always reviewed during medicine reviews.
- Safety alerts were not always actioned in line with national guidance.
- Patients with long-term conditions were not always monitored in line with best practice guidance
- Improvements were needed to the uptake rates of childhood immunisations and cervical cancer screening.
- The provider had attempted to improve patient access, however the impact of these changes was not yet reflected in patient feedback.
- The practice had not identified and managed all risks relating to the management of; legionella management; medicine reviews; safety alerts; access to appointments and patients with long-term conditions.

Safe

Rating: Requires Improvement

We rated the practice as Requires Improvement for providing safe services because:

- The provider had not acted to address risks identified in legionella risk assessments.
- Staff did not always have the appropriate authorisations to administer medicines via the correct use of Patient Group Directions.
- All medicines were not always reviewed during medicine reviews.
- Safety alerts were not always actioned in line with national guidance.

Safety systems and processes

The practice had some clear systems, practices and processes to keep people safe and safeguarded from abuse. However, improvements were needed.

| 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. | 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 |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice had designated safeguarding leads. All staff knew how to identify and report concerns. There were safeguarding policies that were accessible to staff and outlined who to contact if staff had concerns about a patient's welfare.</p> <p>We looked at the training records of 5 staff members and found that all staff were up to date with safeguarding training appropriate to their role.</p> <p>The practice had a safeguarding register. The practice's computer system alerted staff of children that were on the risk register as well as family and other household members of children on the risk register. The safeguarding register was reviewed and updated each week or when new information was available.</p> <p>There were notices around the practice and in clinical rooms advising patients that chaperones were available. We saw that staff who acted as chaperones were trained for the role.</p> | |

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

We looked at the vaccination records of 5 members of staff. We found the provider did not hold evidence of diphtheria, tetanus, or polio vaccinations for 1 member of clinical staff.

| Safety systems and records | Y/N/Partial |
|--|--------------|
| Health and safety risk assessments had been carried out and appropriate actions taken. | Partial |
| Date of last assessment: | October 2022 |
| There was a fire procedure. | Y |
| Date of fire risk assessment: | October 2022 |
| Actions from fire risk assessment were identified and completed. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>We saw the provider had completed health and safety risk assessments and fire risk assessments for Hurley Clinic and Riverside Medical Centre in October 2022. We saw that all identified actions had been completed or had dates for completion.</p> <p>Records showed that calibration testing of equipment and portable appliance testing (PAT) had been carried out within the last 12 months.</p> <p>The provider had a fire evacuation plan, completed testing of the fire alarm system and carried out fire drills. The most recent fire drills took place on 14 April 2023 at Hurley Clinic and 25 August 2023 at Riverside Medical Centre. As a result of these fire drills, the provider had identified actions they needed to take. We saw that all actions had dates for completion.</p> <p>We saw evidence of an inspection of the emergency lighting system at Hurley Clinic on 31 January 2023 and at Riverside Medical Centre on 23 June 2023. The inspection report at Hurley Clinic identified a system failure of the emergency lighting system. We saw evidence the repairs had been scheduled for 21 September 2023.</p> <p>An external company had carried out legionella risk assessments at Hurley Clinic on 13 April 2023 and at Riverside Medical Centre on 14 February 2023. Both risk assessments identified actions that needed to be completed, including several recommendations described as high risk. The provider was advised that these actions should be completed immediately. We requested, but were not provided with, evidence that these actions had been completed.</p> <p>The provider had carried out water sample analysis on 13 April 2023 and 3 July 2023 at Hurley Clinic and 14 February 2023 at Riverside Medical Centre. All 3 samples detected the presence of legionella bacteria in the water system, the volume of legionella bacteria had increased at Hurley Clinic between 13 April and 3 July 2023. We asked the provider for evidence of action taken following these findings. The provider showed us evidence of communication on 14 September 2023 with the company who carried out the analysis. They were advised that the rooms at the practices were safe to use. A repeat water sample analysis had been arranged for both sites.</p> <p>We saw evidence of weekly water temperature checks between February and August 2023 at both sites. The temperatures had been reported at Hurley Clinic in April 2023 and at Riverside Medical Centre in May 2023 as being out of range. However, we could not see evidence of action taken in response to these reports. After our inspection, the provider wrote to us with evidence that an external electrical company had attended the</p> | |

practices in July 2023 and found a tripped fuse. This was fixed and reported that the temperature of the hot water was in the recommended range. Also following our inspection, the provider showed us evidence that they had contacted a specialist in gas and heating to attend the practice to fix the temperatures of the cold water outlets.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

| | Y/N/Partial |
|--|-------------|
| Staff had received effective training on infection prevention and control. | Y |
| Infection prevention and control audits were carried out. | Y |
| Date of last infection prevention and control audit: | 12 May 2023 |
| The practice had acted on any issues identified in infection prevention and control audits. | Y |
| The arrangements for managing waste and clinical specimens kept people safe. | Y |
| Explanation of any answers and additional evidence: The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. We looked at the training records of 5 staff members and saw they had received appropriate training in infection prevention and control (IPC). | |

Risks to patients

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

| | Y/N/Partial |
|--|-------------|
| There was an effective approach to managing staff absences and busy periods. | Y |
| There was an effective induction system for temporary staff tailored to their role. | Y |
| The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures. | Y |
| Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients. | Y |
| There were enough staff to provide appointments and prevent staff from working excessive hours. | Y |
| Explanation of any answers and additional evidence: There was an induction system for all new staff. The practice had a comprehensive business continuity plan for major incidents such as; power failure or building damage. The plan included emergency contact numbers for staff. | |

We looked at the training records of 5 members of staff and found all staff members had completed basic life support training appropriate to their role.

Training records showed that staff had received training in the recognition and management of patients with potential sepsis appropriate to their role.

We saw there was an inventory of emergency equipment and that regular monitoring took place.

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>Review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients.</p> <p>There was a system to ensure referrals, including those referred under the two-week-wait cancer pathway, were managed in a timely manner.</p> | |

Appropriate and safe use of medicines

The practice's systems for the appropriate and safe use of medicines, including medicines optimisation were not always effective.

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

| Indicator | Practice | SICBL average | England | England comparison |
|--|----------|---------------|---------|--------------------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA) | 0.50 | 0.69 | 0.91 | Significant 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). (01/04/2022 to 31/03/2023) (NHSBSA) | 11.3% | 8.0% | 7.8% | Tending towards variation (negative) |
| 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 (01/10/2022 to 31/03/2023) (NHSBSA) | 5.88 | 5.48 | 5.23 | No statistical variation |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA) | 47.8‰ | 73.4‰ | 129.9‰ | Variation (positive) |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA) | 0.15 | 0.37 | 0.55 | Significant variation (positive) |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA) | 3.5‰ | 4.8‰ | 6.8‰ | Variation (positive) |

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

| Medicines management | Y/N/Partial |
|--|-------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Y |
| Blank prescriptions were kept securely, and their use monitored in line with national guidance. | Y |

| | |
|--|---------|
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Partial |
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review. | Y |
| There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. | Partial |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | Y |
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. | Y |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Y |
| There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer. | Y |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | N/A |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Y |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Y |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Y |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Y |
| Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective. | Y |
| <p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>We reviewed 10 Patient Group Directions (PGDs) and found that all of these had been completed incorrectly. This meant that staff did not always have the appropriate authorisation to administer medicines. We shared our findings with the provider. After our inspection the provider sent us evidence that PGDs had now been completed correctly.</p> <p>There were 33 patients prescribed methotrexate (a type of immunosuppressant). We reviewed 4 patients and found that all had the required monitoring tests in line with national guidance. However, 1 patient had 1 test missing from their most recent blood test request. We shared our findings with the provider who showed us evidence that this patient had been contacted to attend for the missing blood test.</p> <p>There were 32 patients prescribed a potassium sparing diuretic (medicines that increase urination). Our review identified 4 patients as possibly not having the required monitoring. We reviewed these patients and found that 3 patients had been monitored appropriately. One patient required monitoring tests, after the inspection the provider showed us evidence that the patient had been contacted to attend for monitoring tests.</p> | |

We identified 58 patients as having 10 or more prescriptions of benzodiazepines or Z drugs (medicines that are used to treat anxiety, insomnia and seizures). We reviewed 5 of these patients and found 3 patients were managed in line with national guidance. We found that 1 patient needed to be reviewed more frequently and 1 patient needed a discussion of the risks associated with these medicines documented in their record. After our inspection the provider showed us evidence that these issues had been addressed with the patients concerned.

We reviewed 5 medicine reviews and found that the quality of these reviews required improvement. For example, in 3 reviews, not all medicines were reviewed. We shared our findings with the provider who developed an action plan on how medicine reviews would be conducted in the future to ensure all medicines were reviewed.

The provider held medical oxygen and a defibrillator at each location, we saw evidence of regular monitoring of these.

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: | 16 |
| Number of events that required action: | 16 |
| Explanation of any answers and additional evidence: We looked at 5 significant events that had been recorded in the last 12 months. We saw the events had been investigated, discussed in clinical meetings and action taken. We saw lessons learned were shared with staff via email and in staff meetings. | |

Examples of significant events recorded and actions by the practice.

| Event | Specific action taken |
|---|--|
| A task for a two-week-wait referral was created, but the referral form was not attached to the task. This meant that the referral was not completed within the specified timeframe. | The referral was later processed correctly. Staff were told they should mark tests as urgent when they contain a two-week-wait referral, and tasks should not be marked as complete until the referral is completed. |

| | |
|--|--|
| A patient requested a home visit, was added to the list, and received a home visit. However, the patient did not meet the provider's criteria for a home visit and should have been booked for a face-to-face or telephone consultation. | This was discussed with the staff member who made the booking. Staff were told they should discuss home visit requests with the duty GP. |
|--|--|

| Safety alerts | Y/N/Partial |
|---|-------------|
| There was a system for recording and acting on safety alerts. | Y |
| Staff understood how to deal with alerts. | N |
| <p>Explanation of any answers and additional evidence:</p> <p>The provider was unable to demonstrate that all relevant safety alerts had been responded to. We reviewed patients on high doses of citalopram or escitalopram (medicines prescribed for depression or anxiety). We saw that patients remained on combinations of medicines that increased their risk of heart problems without anything in their records to indicate this had been identified and the risk discussed with the patient or alternative treatments considered. We shared our findings with the provider who showed us evidence that the patients identified in our search had now been contacted and advised of the risks associated with the medicines. The provider had also implemented a protocol so that alerts were placed on patients prescribed these medicines, as a reminder for clinicians to advise of the associated risks. We also saw the provider had updated the locum pack and discussed the issue in a clinical meeting to increase awareness of clinical staff. Staff had also been informed via email.</p> | |

Effective

Rating: Requires Improvement

We rated the practice as Requires Improvement for providing effective services because:

- Patients with long-term conditions were not always monitored in line with best practice guidance
- Improvements were needed to the uptake rates of childhood immunisations and cervical cancer screening.

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 not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

| | Y/N/Partial |
|---|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | Y |
| 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. | Partial |
| 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. | Partial |
| The practice had prioritised care for their most clinically vulnerable patients during the pandemic. | Y |
| The practice prioritised care for their most clinically vulnerable patients. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>During our inspection, we completed a series of searches on the practice's clinical records system. These searches were completed with consent and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards, and evidence-based guidance.</p> <p>There were 777 patients on the asthma register, 39 of which had been prescribed 2 or more courses of rescue steroids in the last 12 months. We reviewed 5 patients and found that improvements were needed to the management of these patients. For example, patients weren't always followed up within 1 week of an exacerbation, not all patients had an annual asthma review, and there was an incident where antibiotics were</p> | |

prescribed 4 days after they had been requested. We shared our findings with the provider who subsequently produced an action plan to address these issues. For example, clinicians were reminded of the correct processes for urgent prescriptions and patients who were not up to date with annual reviews were contacted to attend for review.

There were 427 patients with hypothyroidism, our searches identified that 22 patients had potentially not had the required monitoring tests. We reviewed 5 of these patients and found that although all patients had a medicine review, the medicines for hypothyroidism had not been reviewed. We shared our findings with the provider who subsequently produced an action plan to address these issues. For example all patients identified were contacted and either booked for monitoring tests, or had their prescriptions reduced to attempt to encourage attendance for monitoring tests.

There were 885 patients with diabetes, our searches identified 91 patients with diabetic retinopathy with their most recent blood tests showing high blood sugar results (diabetic retinopathy is a complication of diabetes, caused by high blood sugar levels damaging the back of the eye. It can cause blindness if left undiagnosed and untreated). We found that improvements were needed to the management of 4 of the 5 patients we reviewed. For example, medicines reviews did not always appear to include a review of diabetes medicine. There was an incident where a patient reported symptoms that required follow-up, however there was a delay in the patient receiving an appointment. We shared our findings with the provider who subsequently developed an action plan to address these issues. For example, patients without up-to-date medicine reviews had these arranged and recorded accurately. The provider gave refresher training to staff to ensure symptoms requiring follow-up were actioned appropriately.

Effective care for the practice population

Findings

- Those identified received a full assessment of their physical, mental, and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles, and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which 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.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- Patients requiring high dose steroid treatment for severe asthma episodes were not always followed up in line with national guidance to ensure they received appropriate care
- Patients with long term conditions were not always reviewed to ensure their treatment was optimised in line with national guidance
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- 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 comorbidities were offered one longer appointment to cover all necessary health checks, reducing the need for multiple appointments.

| 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) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | 120 | 137 | 87.6% | Below 90% minimum |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | 112 | 167 | 67.1% | 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) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | 123 | 167 | 73.7% | Below 80% uptake |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | 60 | 167 | 35.9% | Below 80% uptake |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | 139 | 179 | 77.7% | 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

Childhood immunisations were carried out in line with the national childhood vaccination programme. NHS England results (published in March 2022) showed that uptake rates were lower than the World Health Organisation (WHO) minimum target of 90% for 5 indicators, and below 80% uptake for 4 indicators.

The provider was aware of the published results and had created an action plan to increase uptake of childhood immunisations. There was a dedicated team who held monthly meetings to discuss and review recalls. The provider used a variety of methods to contact the parents or carers of patients who were due immunisations, for example, text message, letter, and phone calls. Parents who declined immunisations were contacted by clinicians via telephone to allow opportunity for discussion and to answer any concerns the parents had. Letters with details of each vaccine were also sent to parents or carers. The provider worked with the health visitor team who would speak to parents to encourage vaccination. The practice offered extended appointments for immunisations to allow time for patients to ask questions and raise concerns.

The provider had reviewed the practice population and identified factors that contributed to low vaccine uptake rates. For example, some patients refused for cultural reasons. There was a transient population, many patients spent significant amounts of time abroad, meaning that sometimes vaccinations would be completed, but outside of the recommended timeframes.

| Cancer Indicators | Practice | SICBL average | England | England comparison |
|---|----------|---------------|---------|--------------------------|
| Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA) | 34.3% | N/A | 62.3% | N/A |
| Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA) | 54.3% | N/A | 70.3% | N/A |
| The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (12/31/2022 to 12/31/2022) (UKHSA) | 47.1% | N/A | 80.0% | Below 70% uptake |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA) | 52.9% | 50.9% | 54.9% | No statistical variation |

Any additional evidence or comments

Published results showed that the uptake for cervical cancer screening was below 70% uptake.

The provider was aware of the published results and had created an action plan to increase uptake of cervical cancer screening. To increase uptake the provider told us; a dedicated team held monthly meetings to discuss and review recalls; patients were contacted using a variety of methods including text message, telephone call and letter; and patients who were reluctant to attend for cervical cancer screening were contacted by a clinician via telephone to discuss concerns.

The provider had reviewed the practice population and identified factors that contributed to low screening uptake rates. For example, some patients refused for cultural reasons. There was a transient population, many patients spent significant amounts of time abroad, meaning that sometimes cervical cancer screening would be completed, but outside of the recommended timeframes.

Data published in March 2023 showed similar results. This data showed the uptake rate for cervical cancer screening was 47%.

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 |
| <p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>We saw evidence of 7 clinical audits that had been carried out in the last 2 years. For example, the provider had completed a 3-cycle audit on patients prescribed adrenaline for the treatment of anaphylaxis. The dose of the medicine is determined by the weight of the patient; therefore an up to date weight should be in the records of each patient prescribed adrenaline to ensure the correct dosage is prescribed. The first audit cycle identified 44% of patients had an up to date weight recorded. The provider made recommendations including education of clinical staff and encouraged patients to weigh themselves using the scales in reception. Pharmacists were asked to send text messages to patients to ask them to submit up to date weights and to follow up by telephone calls any patients who hadn't responded. By the third audit cycle the percentage of patients with an up to date weight recorded had increased to 77%. The provider had implemented further recommendations to reach their target of 100% of patients with an up to date weight recorded.</p> | |

Effective staffing

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

| | Y/N/Partial |
|--|-------------|
| Staff had the skills, knowledge and experience to deliver effective care, support and treatment. | Y |
| The practice had a programme of learning and development. | Y |
| Staff had protected time for learning and development. | Y |

| | |
|---|---|
| There was an induction programme for new staff. | Y |
| Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation. | 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 |
| <p>Explanation of any answers and additional evidence:</p> <p>There was a programme of essential training including, fire safety, infection prevention and control and mental capacity act. Records viewed showed that staff had completed this training.</p> | |

Coordinating care and treatment

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

| | Y/N/Partial |
|---|-------------|
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | 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 |

Explanation of any answers and additional evidence:

We saw that information was available for patients in the waiting room. For example sepsis awareness, support for patients experiencing domestic abuse or eating disorders, and information on local services to support good mental health.

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: We looked at the records of 3 patients with DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) decisions. We found there were clearly documented reasons for the DNACPR decisions that were not discriminatory or based on assumptions about the person’s quality of life, and there was a record of a discussion with the person (and their representative, where appropriate). | |

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 |
| NHS reviews website | There were 4 reviews on the NHS website, 2 were positive and 2 were negative. Positive comments referred to professional and helpful staff, negative comments referred to difficulty accessing blood tests. |
| Experience shared directly with CQC via our website | There were 4 comments received by CQC, these were negative about the service. |

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

| Indicator | Practice | SICBL average | England | England comparison |
|---|----------|---------------|---------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023) | 81.0% | 83.0% | 85.0% | 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 (01/01/2023 to 30/04/2023) | 75.6% | 81.3% | 83.8% | 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 (01/01/2023 to 30/04/2023) | 93.7% | 92.2% | 93.0% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023) | 59.1% | 67.3% | 71.3% | No statistical variation |

| Any additional evidence or comments |
|---|
| Feedback about the practice from the national GP patient survey published in April 2023 was positive and in line with local and England averages. |

| | Y/N |
|---|-----|
| The practice carries out its own patient survey/patient feedback exercises. | Y |

| Any additional evidence |
|--|
| The practice used a variety of methods for patients to feedback including face to face, the use of forms on the practice website, via PPG meetings and as a result of complaints. The practice had acted on this feedback, for example they had introduced a telephone hub to improve access to the practice via telephone. The practice had introduced a direct email address to improve the process for ordering repeat prescriptions. |

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 |

| Source | Feedback |
|---------------------------|---|
| Interviews with patients. | Patients we spoke with told us they received good quality care from the practice and that staff were always professional, treating patients with dignity and respect. |

National GP Patient Survey results

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

| Indicator | Practice | SICBL average | England | England comparison |
|--|----------|---------------|---------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023) | 87.5% | 89.0% | 90.3% | No statistical variation |

| Any additional evidence or comments |
|---|
| Feedback about the practice from the national GP patient survey published in April 2023 was positive and in line with local and England averages. |

| | 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 there were 347 carers in the practice (2% of the practice population). |
| How the practice supported carers (including young carers). | The practice held a list of carers registered with the practice. All patients were asked at registration whether they were a carer and if they would like to be referred to a social prescriber. |
| How the practice supported recently bereaved patients. | Bereaved patients were contacted and support was offered. Patients were also sent details of local organisations who supported recently bereaved people. |

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. | Y |

Responsive

Rating: Requires Improvement

We recognise the pressure that practices are currently working under and the efforts staff are making to maintain levels of access for their patients. At the same time, our strategy makes a commitment to deliver regulation driven by people’s needs and experiences of care. Although we saw the practice was attempting to improve access, this was not yet reflected in the GP patient survey data or other sources of patient feedback. Therefore, the rating is Requires Improvement, as ratings depend on evidence of impact and must reflect the lived experience that people were reporting at the time of inspection.

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: The layout of both Hurley Clinic and Riverside Medical Centre meant that all areas were accessible to people using wheelchairs or mobility scooters. Hearing loops were available at reception. Toilets were accessible to people with limited mobility and there were designated baby changing facilities. Patient areas at Hurley Clinic were located on the ground floor of the building. Riverside Medical Centre was located on the first floor of the building, there was a lift which was accessible for people using wheelchairs or mobility scooters. There were translation services available to support consultations, and the practice website could be translated into languages other than English. The provider offered longer appointments and the option to attend the practice at quieter times to suit the needs of patients. The practice held registers of patients who may need additional support, including those with visual or hearing impairments, so that reasonable adjustments could be made. | |

| Practice Opening Times | |
|------------------------------|------|
| Day | Time |
| Opening times: Hurley Clinic | |

| | |
|---|---------------|
| Monday | 8am – 6.30pm |
| Tuesday | 6.30am - 8pm |
| Wednesday | 8am – 6.30pm |
| Thursday | 8am – 6.30pm |
| Friday | 8am - 6.30pm |
| Appointments available: | |
| Monday | 8am – 6.30pm |
| Tuesday | 6.30am - 8pm |
| Wednesday | 8am – 6.30pm |
| Thursday | 8am – 6.30pm |
| Friday | 8am - 6.30pm |
| | |
| Opening times: Riverside Medical Centre | |
| Monday | 6.30am - 8pm |
| Tuesday | 8am – 6.30pm |
| Wednesday | 6..30am - 8pm |
| Thursday | 6.30am - 8pm |
| Friday | 6.30am -8pm |
| Appointments available: | |
| Monday | 6.30am - 8pm |
| Tuesday | 8am – 6.30pm |
| Wednesday | 6..30am - 8pm |
| Thursday | 6.30am - 8pm |
| Friday | 6.30am -8pm |

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

Patients had a named GP who supported them in whatever setting they lived.

The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. Home visits were triaged, and where appropriate were completed by an advanced nurse practitioner.

There was a medicines delivery service for housebound patients.

The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.

Additional nurse appointments were available until 8pm each day for school age children so that they did not need to miss school.

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 not always able to access care and treatment in a timely way.

| | Y/N/Partial |
|--|-------------|
| Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice. | Partial |
| 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. | Partial |
| There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded). | Y |
| Patients with most urgent needs had their care and treatment prioritised. | Y |
| There was information available for patients to support them to understand how to access services (including on websites and telephone messages). | Y |
| Explanation of any answers and additional evidence: Different appointment types were available, including face to face and telephone consultations. Patients were able to book appointments in person, on the telephone and online. The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs. Patients could also book their own appointments online with some members of the practice team, for example nurse or physiotherapist appointments. On the day of inspection, we looked at the practice's appointment system and found the next available face to face appointment with a GP was 13 September 2023, the next available face to face appointment with a | |

nurse was 14 September 2023, and the next available telephone appointment with a GP was 13 September 2023. However, patient feedback from the national GP patient survey showed dissatisfaction with access to the practice via telephone, the experience of making appointment, the practice appointment times and the appointments offered.

National GP Patient Survey results

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

| Indicator | Practice | SICBL average | England | England comparison |
|---|----------|---------------|---------|--------------------------------------|
| The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023) | 39.8% | N/A | 49.6% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023) | 42.3% | 49.7% | 54.4% | 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 (01/01/2023 to 30/04/2023) | 41.7% | 50.0% | 52.8% | No statistical variation |
| The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023) | 55.9% | 66.2% | 72.0% | Tending towards variation (negative) |

Any additional evidence or comments

The 4 indicators from the national GP patient survey published in April 2023 showed lower than average satisfaction scores. Satisfaction across the 4 indicators had declined since 2021 and has consistently been below local and national averages.

The provider was aware of the published results. They had responded by introducing a telephone hub in April 2023 in the hope this would improve access to the practice via telephone. The telephone system gave live information on the number of patients waiting in the telephone queue. This meant the provider could allocate additional staff to answer the telephones during busy periods. Unverified data provided by the practice showed that before the introduction of the new telephone system the average wait for people calling the practice was 9 minutes. The provider analysed the new telephone system in September 2023 and found the average wait time had reduced to 4 minutes.

The provider felt that some patients were not satisfied with the appointment offered as there was an expectation from patients to be seen by a GP. However, patients were directed to the most appropriate appointment type for their individual needs which may be with a different member of the clinical team, for example a practice nurse, healthcare assistant or first contact practitioner.

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. | 78 |
| Number of complaints we examined. | 5 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 5 |
| 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. | Y |

Example of learning from complaints.

| Complaint | Specific action taken |
|---|--|
| A patient said that a member of staff was rude to them. | The practice apologised to the patient and explained that this experience was not in keeping with the practice’s values. The complaint was discussed with the team and additional training and support was implemented for new and existing staff. |

Well-led

Rating: Requires Improvement

We have rated the practice as Requires Improvement for providing well-led services because:

- The practice had not identified and managed all risks relating to the management of; safety alerts; patients with long-term conditions; medicine reviews; access to appointments and legionella management.

Leadership capacity and capability

Improvements were needed to ensure the delivery of high quality sustainable care.

| | 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. | Partial |
| Staff reported that leaders were visible and approachable. | Y |
| There was a leadership development programme, including a succession plan. | Y |
| We identified the provider had not acted in some areas requiring improvement, for example, action plans to reduce the risk of legionella outbreak and the authorisation of staff to administer medicines via the use of PGDs. | |
| The provider told us one of the GP partners planned to leave the practice in 2024 and had recruited 2 GP partners to replace this GP. There were plans for the newly recruited GPs to start work in the practice in April 2024. | |

Vision and strategy

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

| | Y/N/Partial |
|--|-------------|
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Y |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Y |
| Progress against delivery of the strategy was monitored. | Y |
| Explanation of any answers and additional evidence: | |
| Staff told us they were aware of the practices' vision, values, and strategy and these had been developed by staff working at the practice. They understood their role in supporting the development and achievement of these. The practice's vision could be seen in the waiting rooms. | |

Culture

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

| | Y/N/Partial |
|--|-------------|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | Y |
| Staff reported that they felt able to raise concerns without fear of retribution. | Y |
| There was a strong emphasis on the safety and well-being of staff. | Y |
| There were systems to ensure compliance with the requirements of the duty of candour. | Y |
| When people were affected by things that went wrong, they were given an apology and informed of any resulting action. | Y |
| The practice encouraged candour, openness and honesty. | Y |
| The practice had access to a Freedom to Speak Up Guardian. | Y |
| Staff had undertaken equality and diversity training. | Y |
| Explanation of any answers and additional evidence: We reviewed the training records of 5 staff members and found that all had completed training in equality and diversity. Staff told us the management team were visible and approachable and there was a supportive environment at the practice. | |

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

| Source | Feedback |
|--------------------------------------|--|
| Staff interviews and feedback forms. | We interview 5 members of staff and received 14 staff feedback forms. Staff told us they were able to raise concerns and gave examples of where staff feedback had resulted in improvements for patients. Staff told us they felt valued and they enjoyed being part of this team. Staff also gave feedback on where they would like to see improvements. For example, comments referred to a desire for increased number of salaried GPs and improved retention of staff. |

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

| | Y/N/Partial |
|---|-------------|
| There were governance structures and systems which were regularly reviewed. | Y |
| Staff were clear about their roles and responsibilities. | Y |
| There were appropriate governance arrangements with third parties. | Y |

| | |
|---|---|
| There are recovery plans in place to manage backlogs of activity and delays to treatment. | Y |
|---|---|

Managing risks, issues and performance

There were not always clear and effective processes for managing risks, issues and performance.

| | Y/N/Partial |
|--|-------------|
| There were comprehensive assurance systems which were regularly reviewed and improved. | Y |
| There were processes to manage performance. | Y |
| There was a quality improvement programme in place. | Y |
| There were effective arrangements for identifying, managing and mitigating risks. | 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. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>Our inspection identified that improvements were required in relation to management of risks relating to:</p> <ul style="list-style-type: none"> • Legionella management • PGDs • Medicine reviews • Safety alerts • The management of patients with long-term conditions • Uptake of childhood immunisations • Uptake of cervical cancer screening • Patient access <p>The provider had an action plan to address the risks relating to:</p> <ul style="list-style-type: none"> • Uptake of childhood immunisations • Uptake of cervical cancer screening • Patient access <p>As a result of our inspection, action had been taken in relation to the risks of:</p> <ul style="list-style-type: none"> • PGDs • Medicine reviews • Safety alerts • The management of patients with long-term conditions <p>However the provider still needed to address the risks relating to:</p> <ul style="list-style-type: none"> • Legionella management | |

Appropriate and accurate information

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

| | Y/N/Partial |
|---|-------------|
| Staff used data to monitor and improve performance. | Y |
| Performance information was used to hold staff and management to account. | Y |
| Staff whose responsibilities included making statutory notifications understood what this entailed. | Y |

Governance and oversight of remote services

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

Engagement with patients, the public, staff and external partners

The practice involved 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:

The practice had an active patient participation group (PPG) who held meetings with practice representatives every 2 months. We heard that the practice worked together with the PPG to listen to patients' views and make improvements. For example the practice's phone and appointment systems had improved as a result of patient feedback. The PPG also said they would like to see an increase in salaried GPs.

Continuous improvement and innovation

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

| | Y/N/Partial |
|--|-------------|
| There was a strong focus on continuous learning and improvement. | Y |
| Learning was shared effectively and used to make improvements. | Y |
| Explanation of any answers and additional evidence: Complaints and significant events were used to make improvements. We saw evidence that learning from complaints and significant events was shared with staff. Staff told us they attended meetings where learning was shared. | |

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

| Variation Bands | Z-score threshold |
|----------------------------------|-------------------|
| Significant variation (positive) | ≤ -3 |

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

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

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

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

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

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

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

Glossary of terms used in the data.

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