

## Inspection Evidence Table

The Bacon Lane Surgery

(1-547815788)

Inspection Date: 4 & 5 July 2023

Date of data download: 15/06/2023

**Overall rating: Requires improvement**

**Safe** **Rating: Requires improvement**

At the previous inspection in April 2022, we rated the practice as requires improvement for providing safe services because:

- We found that some members of staff, both clinical and non-clinical, had not completed the appropriate level of safeguarding training.
- We found gaps in the training records we reviewed, in particular in relation to sepsis awareness and information governance training. The practice told us that this had been completed by all staff, however, we did not see evidence of this in all cases.
- We found that whilst monitoring was completed appropriately for some high risk medicines, we found some issues with the monitoring of patients on some medicines.
- We found that the system for managing and acting on Medicines and Healthcare Products Regulatory Agency (MHRA) alerts was not always effective.

At this inspection in July 2023, we found some improvements had been made, however, we found additional concerns and the practice was required to make further improvements. We rated the practice as **requires improvement** for providing safe services because:

- Our clinical records searches showed that the practice did not always have an effective process for monitoring patients' health in relation to the use of medicines including medicines that require ongoing monitoring.
- Risks to patients were not assessed and well managed in relation to some medication reviews, some emergency medicines, the fire evacuation plan and the implementation of national patient safety and medicines alerts.
- Recruitment checks including Disclosure and Barring Service (DBS) were not always carried out in accordance with regulations and some records were not kept in staff files.
- There was a system in place to monitor the use of blank prescription forms and pads. However, it did not work as intended.

## Safety systems and processes

**The practice had systems, practices and processes to keep people safe and safeguarded from abuse. However, improvements were required.**

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.	Partial
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> <ul style="list-style-type: none"><li>• At the previous inspection in April 2022, we found gaps in the training records of staff members and some staff members had not completed safeguarding training to the appropriate level.</li><li>• At this inspection in July 2023, we found all staff had received safeguarding children, safeguarding adults, infection control and fire safety training relevant to their role.</li><li>• Disclosure and Barring Service (DBS) checks were not always undertaken appropriate to the role where required. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. For example, we noted that a clinical pharmacist (employed by the practice) had received a 'standard' DBS check which was not appropriate to their role. They started working at the practice on 28 February 2022 and received the 'standard' DBS on 27 June 2023. In addition, the operational manager and practice supervisor had received the 'standard' DBS, which was not appropriate to their role.</li><li>• Staff who acted as chaperones were trained for the role. Most non-clinical staff who acted as chaperones had received a 'standard' Disclosure and Barring Service check (DBS check), which was not appropriate to their role and an appropriate risk assessment was not completed.</li><li>• Shortly after the inspection, the practice informed us that they were going to process applications for DBS checks at the appropriate level.</li><li>• There was a Female Genital Mutilation (FGM) policy in place.</li></ul>	

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> <ul style="list-style-type: none"> <li>We noted that appropriate recruitment checks had not always been undertaken prior to employment. For example, the three staff files we reviewed showed that references (satisfactory evidence of conduct in previous employment) and appropriate health checks (satisfactory information about any physical or mental health conditions) had not been undertaken prior to employment for one staff. Interview notes were not kept in two staff files. A contract was not available, and two contracts were not signed appropriately. A passport or evidence of the right to work in the UK was not kept in the staff file available for staff.</li> <li>Staff vaccination was maintained in line with current UKHSA guidance.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: 12 April 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: 17 June 2022	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Staff had received fire safety training.</li> <li>The fire system was regularly serviced and there was a record of fire alarm checks.</li> <li>The practice carried out regular fire drills.</li> <li>There was a documented fire evacuation plan in place. However, it did not include how staff could support patients with mobility problems to vacate the premises.</li> <li>Emergency lighting was inspected regularly.</li> <li>A gas safety check was carried out in March 2023.</li> <li>Portable appliance testing was carried out in May 2023.</li> <li>There were records of equipment calibration which was carried out in May 2023.</li> <li>The fixed electrical installation check was carried out in March 2022.</li> </ul>	

## 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: June 2023.	Y
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: <ul style="list-style-type: none"><li>• We noted appropriate standards of infection prevention and control were maintained.</li><li>• Clinical equipment was cleaned on a regular basis and records were maintained.</li><li>• We saw a cleaning schedule was in place and records were maintained.</li><li>• The legionella risk assessment was carried out in May 2023 and regular water temperature checks were carried out. Legionella is a term for a particular bacterium which can contaminate water systems in buildings. We noted a laboratory analysis of a water sample was carried out.</li><li>• Staff had received infection control training.</li></ul>	

## Risks to patients

**There were systems in place to assess, monitor and manage risks to patient safety. However, some improvements were required.**

	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.	Partial
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: <ul style="list-style-type: none"><li>• The practice operated a system to organise annual leave and cover for unexpected absences.</li><li>• All requests for home visits were triaged by the duty GP.</li><li>• All staff had received sepsis awareness training.</li><li>• Staff had received basic life support training.</li><li>• The practice was equipped to respond to medical emergencies and emergency equipment was checked regularly. However, some emergency medicines were not in the stock and documented risk assessment was not carried out.</li><li>• There was public awareness information on the practice's website.</li></ul>	

**Information to deliver safe care and treatment**

**Staff had the information they needed to deliver safe care and treatment. However, some improvements were required.**

	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.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"><li>A review of patient records identified that care records were not always managed in line with current guidance. For example, our clinical records searches showed that the practice did not always carry out required tests in a timely manner. Our findings are discussed in detail in the section below.</li></ul>	

## Appropriate and safe use of medicines

**The practice had some systems for the appropriate and safe use of medicines, including medicines optimisation. However, improvements were required.**

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)	0.69	0.68	0.91	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). (01/04/2022 to 31/03/2023) (NHSBSA)	5.9%	7.7%	7.8%	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 tract infection (01/10/2022 to 31/03/2023) (NHSBSA)	5.48	5.45	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	52.1‰	57.9‰	129.8‰	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)	0.55	0.43	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	2.0‰	4.7‰	6.8‰	Significant 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.	Partial
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 effective 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 medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England 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.	N
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> <ul style="list-style-type: none"> <li>At the previous inspection in April 2022, we found that whilst monitoring was completed appropriately for some high risk medicines, we found some issues with the monitoring of patients on some medicines.</li> <li>At this inspection in July 2023, our clinical records searches showed that the practice did not always have an effective process for monitoring patients' health in relation to the use of medicines including medicines that require ongoing monitoring. For example:</li> <li>We reviewed five patients being prescribed medicine used to treat thyroid hormone deficiency, which required patients to receive regular blood test monitoring. We found that one patient did not have their blood test in a timely manner. In addition, three patients were overdue medicine reviews. The practice informed us they had contacted and invited the patients. However, they failed to attend appointments for medicine reviews.</li> <li>After the inspection, the practice submitted an action plan to address the clinical issues identified during the inspection. The practice assured us that these patients had been contacted or would be contacted and followed up.</li> <li>We found that blank prescription boxes and handwritten prescription pads were stored securely in locked cabinets. We noted the boxes serial numbers and stock were not entered in any logbook. We found that blank prescription forms (for use in printers) serial numbers were recorded and tracked through the practice. However, they were not always recorded correctly. The handwritten prescription pads stock was not recorded. However, serial numbers were recorded in a logbook when they were used.</li> <li>We noted some emergency medicines were not in stock. For example, diazepam (used to treat seizures), benzylpenicillin (used to treat a bloodstream infection) and diclofenac injection (used to treat pain). The provider informed us that some emergency medicines were facing long-term manufacturers' delays. However, the practice had not carried out a documented risk assessment to explain how they would manage an emergency situation when these medicines were not available in stock.</li> </ul>	

- The practice had an effective system to support vulnerable patients with requesting and collecting prescriptions. This involved checking the prescription box regularly and contacting the patient to check if they still required the medication or if a new prescription was issued.
- The practice had an effective system to identify and monitor who was collecting repeat prescriptions for controlled drugs from the reception.
- The practice worked closely with the local ICB medicines management team regarding the safe prescribing of antibiotics, within national guidance, and medicines optimisation.
- The practice was working closely with a clinical pharmacist provided by the local primary care network (PCN).
- Vaccines were appropriately stored in the fridges and fridge temperatures were monitored regularly. The practice had a secondary thermometer in the fridge used to store vaccines, which logged all the data and provided assurance that temperatures had stayed within the required range, as recommended in Public Health England guidance.

### 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• We found that the log of the significant events was maintained. We saw in staff meeting minutes that significant events were discussed and documented. The staff we spoke with informed us that learning from significant events had been shared with them on a regular basis.</li> </ul>	

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

Event	Specific action taken
Conflicting urine test results information shared with the patient.	The practice investigated the incident and apologised to the patient. The practice delivered additional training to the reception staff and reminded them to follow the protocol when dealing with a request related to the pathology results.



Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the previous inspection in April 2022, we found that the system for managing and acting on Medicines and Healthcare Products Regulatory Agency (MHRA) alerts was not always effective.</li> <li>At this inspection in July 2023, our clinical records searches showed that the practice had a system in place to manage safety alerts, but it did not always work effectively. The practice was unable to demonstrate that all relevant safety alerts had been responded to. For example, we reviewed five patients prescribed both aldosterone antagonist (used to treat high blood pressure and heart failure) medicine and angiotensin-converting enzyme (ACE) inhibitors/ angiotensin receptor blockers (ARBs). We found that four patients had not had blood test monitoring to check kidney function in the last six months. Patients taking this combination of medicines are at increased risk of developing severe hyperkalaemia (higher than normal potassium levels in the blood) if not monitored appropriately.</li> <li>After the inspection, the practice submitted an action plan to address the clinical issues identified during the inspection. The practice assured us that these patients had been contacted or would be contacted and were going to be followed up.</li> <li>The practice had a safety alerts protocol and kept a computerised log of all patient safety alerts which was saved centrally. The practice discussed alerts at practice meetings and would save the minutes on Teams for staff to review.</li> </ul>	

## Effective

## Rating: Requires improvement

At the previous inspection in April 2022, we rated the practice as requires improvement for providing effective services because:

- We identified some issues with the monitoring and management of long-term conditions.
- The practice's uptake of the national screening programme for cervical cancer screening and childhood immunisation uptake was below the national average.

At this inspection in June 2023, we found some improvements had been made, however, we found additional concerns and the practice was required to make further improvements. We rated the practice as **requires improvement** for providing effective services because:

- Patient treatment was not always regularly reviewed and updated.
- Our clinical records searches showed that the practice was not systematically monitoring patients with asthma in line with guidelines; potential missed diagnoses of Chronic Kidney Disease (CKD) and patients prescribed medicine to treat thyroid hormone deficiency.
- Some medicine reviews for patients with long-term conditions were not carried out in a timely manner.

*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. We found some gaps and improvements were required.**

	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.	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.	Y

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> <ul style="list-style-type: none"> <li>We found issues with the management of medicines and following clinical guidance. In particular, our clinical records searches found concerns related to the management of patients with asthma, potential missed diagnosis of Chronic Kidney Disease (CKD) and medicine used to treat thyroid hormone deficiency.</li> </ul>	

## Effective care for the practice population

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was an appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with underlying medical conditions according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example, diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. However, during our clinical records searches, we found some areas where improvement was required.
- Patients with asthma were offered an asthma management plan. However, we reviewed five patients with asthma who had been prescribed two or more courses of oral steroids in the last 12 months and found one weekly follow-up was not carried out for four patients after prescribing steroids.
- We reviewed five patients with diabetic retinopathy (disease of the retina) whose latest HbA1c was >74mmol/l. We found that one patient did not have their blood test in a timely manner.
- We reviewed five patients and found issues with coding/ potential missed diagnosis of Chronic Kidney Disease (CKD) for one of these patients. This patient had not received the appropriate lifestyle advice, monitoring or appropriate medication to protect them and improve their health.
- We reviewed five patients and found that the practice had completed medication reviews for all five patients in the last 3 months. However, we noted there was limited information recorded in three medication reviews.
- After the inspection, the practice submitted an action plan to address the clinical issues identified during the inspection. The practice assured us that these patients had been contacted or would be contacted and followed up.
- 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 with patients who had received treatment in the hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- 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.

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)	83	102	81.4%	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)	89	108	82.4%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	83	108	76.9%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	84	108	77.8%	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)	80	98	81.6%	Below 90% minimum

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

### Any additional evidence or comments

- At this inspection in May 2023, we found that the practice had demonstrated improvements in childhood immunisation uptake compared to the previous inspection in April 2022.
- Childhood immunisations were carried out in line with the national childhood vaccination programme. However, childhood immunisation uptake rates were below the World Health Organisation (WHO) targets for all 5 immunisation indicators measured in 2021/22. The practice explained that this was due to the transient population and challenges within the practice area. For example, the practice identified that some children were not living in the country or had childhood immunisation carried out in their native countries, but formal evidence of immunisation had not been shared with the practice.
- The practice told us that it had a high proportion of asylum seekers and Romanian patients, who did not wish to have their children vaccinated despite several attempts to raise awareness about the importance and benefits of the programme with posters, text messaging and telephone calls.
- The practice informed us there was a high refusal rate for immunisation for measles, mumps and rubella (MMR).
- The practice had taken steps to improve childhood immunisation uptake. The practice conducted a thorough analysis of the data and identified targeted areas to improve performance. The practice had

maintained a register and a dedicated staff was contacting the parents or guardians of children and encouraging childhood immunisation uptake.

- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up on failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- The practice nurse had received regular annual training updates relevant to childhood and travel immunisations.
- The practice informed us they increased the practice nurse hours and also offered Saturday appointments (as part of the Primary Care Network) to increase the uptake.

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)	63.6%	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)	61.7%	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). (3/31/2023 to 3/31/2023) (UKHSA)	63.8%	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)	36.1%	55.1%	54.9%	No statistical variation

### Any additional evidence or comments

- According to the UK Health Security Agency (UKHSA) published data, the practice population uptake rates for national cancer screening programmes were below the England average.
- The practice explained that this was due to the transient population, high number of asylum seekers and known cultural beliefs within the practice population, which meant that these patients were coded as 'smear not wanted' annually.
- The practice had taken steps to encourage uptake. For example, the practice informed us that they were actively involved with cervical screening and allocated a dedicated staff member to call and invite patients which resulted in better uptake of the test. They increased practice nurse working hours and offered weekend nurse clinics (as part of the primary care network) to promote and encourage patients to have the test done.
- There was a policy to offer telephone reminders and send text messages to patients who did not attend for their cervical screening test. All non-attendance was flagged on the patient's record so that the clinicians opportunistically encouraged patients to make their appointments. However, further improvements were required to meet the 80% coverage target for the national screening programme.
- The practice had shared Quality Outcomes Framework (QOF) results and informed us they had achieved 82% cervical cancer screening rates for patients aged 25-49 years and 82% screening rates for patients aged 50-64 years old. While these results are encouraging, this unverified QOF data was not comparable with the UK Health and Security Agency published data (Snapshot date: 31/03/2023) included in this report. The cervical screening QOF indicator was used to calculate the payment the practice received, not the number of women screened. It included women who had been invited but who had not attended. In addition, it did not measure whether women had been screened at the appropriate time according to their age.
- The practice had a system to ensure results were received for all samples sent for the cervical screening programme. The practice had established failsafe systems to follow up with women who were referred for treatment or investigation as a result of abnormal results.
- We noted a practice nurse had received specific training on sample taking for the cervical screening programme.

### 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
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ul style="list-style-type: none"><li>• The practice carried out repeated clinical audits to review and monitor the appropriateness of high-risk medicines prescribed. The aim of the audits was to identify and ensure appropriate documentation and effective monitoring including appropriate dosage, length of supply and appropriate frequency of prescribing in line with local and national guidelines.</li><li>• The practice carried out repeated clinical audits of antibiotics prescribed to ensure patient safety.</li><li>• The practice carried out a repeated clinical audit of diabetic patients to ensure HbA1c (the amount of blood sugar) was monitored regularly.</li><li>• The practice carried out a drug dependency audit and patients were made aware of the risk of addiction and adequately educated on sleep hygiene, and given the option of switching the medicine, if appropriate.</li></ul>	



### 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• All staff received annual appraisals in a timely manner.</li><li>• Staff had received safeguarding children, safeguarding adults, sepsis awareness, chaperone and fire safety training relevant to their role.</li><li>• We noted practice nurses had received regular annual training updates relevant to travel immunisations and childhood immunisations in the last 12 months.</li></ul>	

### 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice acted on communication from external services to maintain continuity of care.</li></ul>	

### 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: <ul style="list-style-type: none"><li>• Staff we spoke with described how patients were referred to other services, for example, to the health visitor, social services and social prescriber.</li></ul>	

### 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, including from clinical searches: <ul style="list-style-type: none"><li>• Our clinical review of notes where a DNACPR decision had been recorded, identified that where possible, the patients' views had been sought and respected. We saw that information had been shared with relevant agencies.</li></ul>	

## Responsive

## Rating: Requires improvement

At this inspection in July 20223, we rated the practice as requires improvement for providing Responsive services because:

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

### 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"><li>• The practice understood the needs of its population and tailored services in response to those needs. For example, the practice was proactive in offering online services, which included online appointment booking, an electronic prescription service and online registration. Patients could also request fit notes via the practice website and repeat medicines by e-consult, Patient Access website, email or by the pharmacist.</li><li>• The practice had analysed where it could improve and told us that it would like to improve its premises further; continue working on access and continuity by improving e-consulting triage and providing appropriate appointments; optimising and utilising allied healthcare staff; and supporting staff during difficult periods.</li><li>• The practice made reasonable adjustments when patients found it hard to access services. For example, there were accessible facilities, which included a disabled toilet and a hearing induction loop was available. The practice ensured that patients with mobility issues were seen in an accessible room.</li><li>• The practice offered an in-house phlebotomy (to withdraw blood) service.</li><li>• The practice signposted patients to the social prescriber, Age UK, faith organisations, and societies for specific health problems such as Raynaud's disease and Alzheimer's disease.</li><li>• The practice website was well designed, clear and simple to use featuring regularly updated information. The practice website included a translation facility.</li><li>• The practice sent text message reminders of appointments.</li></ul>	

Practice Opening Times	
Day	Time
<b>Opening times:</b>	
Monday	8.00am-6.30pm
Tuesday	8.00am-6.30pm
Wednesday	8.00am-6.30pm
Thursday	8.00am-6.30pm
Friday	8.00am-6.30pm
<b>Extended hours opening:</b>	
Monday to Friday (at local GP Access centres/ hubs)	7pm-8.30pm
Saturday (at local GP Access centres/ hubs)	9.00am-5.00pm

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Extended hours appointments were available at local hubs in the evening and on the weekends.
- 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.
- The practice had participated in the vaccination programme, contributing to the Primary Care Network (PCN) being the leading provider of vaccinations in London.
- The practice ethos was to provide patient-centred care, allow flexible appointment lengths to allow a holistic approach, demonstrate a commitment to teamwork and was an established teaching and training practice.
- The practice had analysed its practice population. It had a high proportion of elderly patients compared to other boroughs, a high Asian ethnic cohort, a high proportion of asylum seekers, a high number of diabetic patients, a non-English speaking population and a migrant population. The practice acknowledged that widespread ethnic diversity brought challenges and was working to meet these challenges.

## Access to the service

### People were not 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"><li>• The GP National Survey data reflected that patients did not always have timely access to appointments or in a way which met their needs.</li><li>• The practice utilised an online triage system which was accessible via their website. The aim of using online triage was to provide a more convenient way for patients to communicate with the practice, as well as empowering and educating the patient on self-care options. The system allowed patients to submit information about their symptoms, request doctors' letters, ask about test results, or review information on common problems. The practice responded to these requests. If queries were clinical in nature, they were allocated to a GP for review. The GP would provide feedback via the portal, or request the patient book an appointment.</li><li>• The practice understood that some patient groups needed support, for example older people, who were unable to use the e-consultation system. It told us that reception staff would complete an e-consult light, which was a shorter form that was completed by reception staff with information provided by a patient, with these patients either over the telephone or in a side room if they had attended the practice in person.</li><li>• Appointments were offered and undertaken by telephone, video consultation and on a face to face basis.</li><li>• The practice informed us they supported access for people with different communication needs. For example, the use of interpretation services during consultations when required.</li><li>• The practice had identified patients who were vulnerable or who would have difficulties accessing the service and had flagged them on their computer system. They would offer those patients home visits as a priority.</li><li>• In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for patients who needed them.</li></ul>	

## 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
	2022	2023	2022	2023	2022	2023	2022
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	51.1%	44.6%	N/A	N/A	52.7%	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 (01/01/2022 to 30/04/2022)	52.7%	37.0%	58.2%	57.4%	56.2%	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 (01/01/2022 to 30/04/2022)	55.2%	42.2%	58.9%	57.1%	55.2%	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 (01/01/2022 to 30/04/2022)	63.7%	58.7%	68.5%	69.7%	71.9%	72.0%	No statistical variation

### Any additional evidence or comments

- 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 for responsive key question 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.
- The actions the practice had taken in the past were not improving data, particularly in the last year when all satisfaction rates for the year 2023 have got worse. We saw a downward trend since 2022 for most of the indicators in the National GP survey results.
- The practice had 9,570 patients registered with the practice. On the day of the inspection, we found the practice offered 31 GP clinical sessions per week (including 7 trainee GP clinical sessions). In addition, two clinical pharmacists (both non-prescribers) were employed by the practice and offered 72 hours per week at the practice.

- The practice offered 17 practice nurse clinical hours per week. In addition, a Musculoskeletal (MSK) specialist and two Health Care Assistants (HCAs) were working full time at the practice.
- The practice informed us telephone system included a queueing facility and enabled remote monitoring from the dashboard available in their computer system.

Source	Feedback
NHS.uk website (formerly NHS Choices)	<ul style="list-style-type: none"> <li>• Seven reviews in the past year. Four reviews were positive, and three reviews were negative.</li> <li>• One negative review was related to poor access to the service. However, four positive reviews appreciated the satisfactory access provided by the practice.</li> </ul>
Discussion with the patient participation group (PPG) members and a patient	<ul style="list-style-type: none"> <li>• Three PPG members and a patient we spoke with praised the practice for efficiently adapting the service in line with the evolving pandemic, whilst maintaining an accessible and supportive service.</li> <li>• They were satisfied with the access provided by the practice. They said they were able to get the appointment when needed. They appreciated the automatic call-back service offered by the telephone system.</li> </ul>

## 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.	43
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Example(s) of learning from complaints.

Complaint	Specific action taken
A childhood immunisation appointment was incorrectly booked.	The practice investigated the complaint and apologised to the parent of the child. The practice offered relevant training to the staff and reminded them to follow the protocol and ensure there should be a month gap between each vaccine when booking in advance.



## Well-led

## Rating: Requires improvement

At the previous inspection in April 2022, we rated the practice as requires improvement for providing well-led services because:

- The practice had a governance framework, however it was not always effectively managing risks. These included the risks associated with the required monitoring of patients on some high-risk medicines, actioning of patient safety alerts, management of long-term conditions and uptake of childhood immunisations and cervical screening.
- The system for oversight of staff training was not sufficient.

At this inspection in June 2023, we found some improvements had been made, however, we found additional concerns and the practice was required to make further improvements. We rated the practice as **requires improvement** for providing well-led services because:

- There was a lack of effective governance in some areas, which included the monitoring of medicines that require ongoing monitoring, gaps in recruitment checks, emergency medicines, management of blank prescription forms and safety alerts.

### 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: <ul style="list-style-type: none"><li>• Staff we spoke with were complimentary about the leadership at the practice. We were told that the leaders were approachable, supportive and inclusive.</li><li>• The practice did not currently have a practice manager in a post as they were unable to recruit suitable candidates. However, one of the partners was performing practice management duties.</li></ul>	

## 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: <ul style="list-style-type: none"><li>The practice had a mission statement which included improving the health, wellbeing and lives of those cared for and ensuring clinical excellence and operational efficiency. The practice stated that it would strive to put patients at the centre of everything it did, treat patients with courtesy, dignity and respect at all times, provide the highest quality care to meet the needs of patients, involve patients in decision making about their care and treatment, promote health and wellbeing in the prevention of disease, be a learning organisation that continually improves, nurture a culture which was innovative a culture which was forward looking and adaptable, value the contribution of each team member, ensure staff have the right skills and training to carry out their roles and take care of staff by offering them support to do their jobs and to protect against abuse.</li><li>Staff we spoke with were fully conversant with the vision and values and evidenced their understanding and role in achieving this.</li></ul>	

## 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: <ul style="list-style-type: none"><li>We received feedback in staff interviews that suggested that there was a positive relationship between staff and management, with staff reporting that they enjoyed working at the practice.</li></ul>	

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

Source	Feedback
Staff feedback	<p>We spoke with a mix of staff during the inspection:</p> <ul style="list-style-type: none"> <li>• All the staff interviewed reported a positive experience of working at the practice.</li> <li>• Staff described a positive learning environment where they were supported and encouraged to complete training and professional development.</li> <li>• Staff felt they were treated equally.</li> <li>• We were informed that the practice culture was one of being open and supportive of one another.</li> <li>• Clinical staff said they had prompt access to the senior GP when they needed clinical advice.</li> </ul>

## Governance arrangements

**There was a lack of good governance in some areas and improvement was required.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>There was a lack of good governance in some areas, in particular:</p> <ul style="list-style-type: none"> <li>• We found some gaps in staff recruitment checks including Disclosure and Barring Service (DBS) checks. For example, we noted that the DBS was not always processed in a timely manner. We saw a clinical pharmacist was employed in February 2022 and their DBS check was received in June 2023. The practice had obtained a 'standard' DBS check rather than an 'enhanced' check which was appropriate to their role. The practice had not carried out a documented risk assessment to mitigate the risk.</li> <li>• Some staff documents were not accessible at the time of the inspection.</li> <li>• The practice did not have an effective monitoring system in place to assure themselves that blank prescription forms and handwritten pads were recorded correctly. There was a system in place. However, it did not work as intended.</li> <li>• The practice did not have an effective system to act on feedback and improve patient satisfaction regarding access to the service, as there was a downward trend in 2023 and the National GP survey data had been below local and national averages over time.</li> <li>• There were a range of practice specific policies which were available to all staff. These were reviewed annually and updated when necessary.</li> </ul>	

### Managing risks, issues and performance

**There were processes for managing risks, issues and performance. However, some improvements were required.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• There were processes to ensure risks to patients were assessed and well managed in most areas, with the exception of those relating to some medication reviews, some emergency medicines, the fire evacuation plan and the implementation of national patient safety and medicines alerts.</li><li>• The practice did not always have an effective process for monitoring patients' health in relation to the use of medicines including medicines that require ongoing monitoring. This issue was highlighted during the previous inspection.</li><li>• The practice had implemented processes to monitor clinical performance and quality of care within the practice.</li><li>• There were a variety of daily, weekly and monthly checks in place to monitor the performance of the practice.</li><li>• Clinical audits were carried out.</li><li>• The practice had a business continuity plan in place.</li></ul>	

### 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 the public, staff and external partners to sustain high quality and sustainable care.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"><li>• Patients had a variety of means of engaging with the practice all of which were effective: text messages, emails and complaints/comments.</li><li>• Staff feedback highlighted a strong team with a positive supporting ethos.</li><li>• Staff said the leadership team proactively asked for their feedback and suggestions about the way the service was delivered. Staff meetings were held regularly.</li><li>• The practice worked closely with their Primary Care Network (PCN). This was particularly evident at the onset of the pandemic when communication with the PCN was regular.</li><li>• We noted the NHS friends and family test (FFT) results for the last 12 months (July 2022 to July 2023) which showed that 93% of patients (out of 108 responses) were likely or extremely likely to recommend this practice.</li></ul>	

## Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"><li>• We spoke with three Patient Participation Group (PPG) members, and they were positive about the care and treatment offered by the practice, which met their needs.</li></ul>

### 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>The practice shared learning from significant events and made improvements as a result of lessons learned.</li></ul>	

### Examples of continuous learning and improvement

- The practice had an ethos of improvement and innovation and was working towards improving services.
- The practice had worked with the community to educate on health issues such as cancer and heart failure, with doctors providing talks which were published online.
- The practice shared learning from significant events and made improvements as a result of lessons learned.
- The practice worked in an integrated way with neighboring practices and pharmacists. A senior GP was teaching other local GPs about various long term conditions including diabetes, kidney failure and heart conditions.
- A senior GP was working closely with the PCN and delivering teaching sessions to local GPs regarding cardiology, physiotherapists regarding joint injections and technicians regarding ECG. An electrocardiogram (ECG) records the electrical signal from the heart to check for different heart conditions.

## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$



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 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 those aged 25 to 49, and within 5.5 years for those 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.