

Care Quality Commission

Inspection Evidence Table

Earl's Court Surgery (1-2310368016)

Inspection date: 2 September 2021

Date of data download: 10 September 2021

Overall rating: Requires improvement

At our previous inspection on 7 March 2020, we rated the practice as requires improvement overall. This was because we identified concerns relating to the safe, effective and well-led key questions. We rated the practice as good for providing caring and responsive services. At this inspection carried out between 1 and 2 September 2021, we rated the practice as requires improvement. This was because we identified ongoing concerns relating to the provision of safe, effective and well-led services. Please see below for detailed findings.

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

Safe

Rating: Good

At our previous inspection in March 2020, we rated the practice as requires improvement for providing safe services because:

- There was no assessment of the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. In particular:
 - We were unable to see evidence of historical infection control audits and therefore could not be assured that previous potential recommendations had been followed.
- Not all of the people providing care and treatment had the qualifications, competence, skills and experience to do so safely. In particular,
 - The practice was unable to provide vaccination records for some members of staff.
- The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:
 - The practice was unable to demonstrate records associated with fire drills conducted and fire extinguishers.

At this inspection, we found that these areas had been addressed. The practice was therefore rated as good for providing safe services.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At our previous inspection in March 2020, we found that the practice could not demonstrate compliance with the Royal College of Nursing's published intercollegiate guidance on "Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff" in January 2019 which specified that all GP's were trained to level 3 in both adults and children. We found that the practice did not always carry out DBS checks when required. At this inspection, we found that GPs had now completed the appropriate Safeguarding training. This was an improvement since our previous inspection. We found that DBS checks had been completed for staff with the exception of one receptionist. The practice informed us that there had been some difficulties in requesting the DBS check but that it would progress this. The member of staff had been trained as a chaperone and the practice assured us that they would not be undertaking any chaperoning responsibilities until their DBS check had been received. Nursing staff had a process in place for following up patients at risk who had missed appointments and escalating where required. Clinical staff told us about the processes for monitoring potential patients at risk of female genital mutilation (FGM) and escalation of risks. However, we were not assured that there was proactive management of these risks, for example the practice did not fully explain how it monitored younger patients at risk. 	

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 Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We reviewed staff files for two clinical and one non clinical members of staff. We found that appropriate recruitment checks had been undertaken prior to employment. There was an outstanding DBS check for the non clinical member of staff we reviewed but the practice told us this was in progress. 	

Safety systems and records	Y/N/Partial
<p>There was a record of portable appliance testing or visual inspection by a competent person.</p> <p>Date of last inspection/test: 27 January 2021</p>	Y
<p>There was a record of equipment calibration.</p> <p>Date of last calibration: 13 January 2021</p>	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
<p>A fire risk assessment had been completed.</p> <p>Date of completion: 11 November 2020</p>	Y
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> A comprehensive health and safety, fire, disability access and legionella risk assessment was completed by an external company in November 2020. A number of actions were identified during these risk assessments in relation to fire, disability access and legionella. Following our site visit, the practice forwarded us a copy of its action plan. There were eight outstanding items to be actioned but there was no date within the action plan or any details about who was responsible to action each issue. Action had been taken with regard to installing a hearing loop and signage about this facility and monthly checks on hot water temperatures. During our site visit we observed items in the staff kitchen areas in the basement and on the first floor which had not been PAT tested (kettles). We also observed a fridge in the staff room which had not been PAT tested recently (sticker indicated PAT testing in November 2011). 	

- The practice conducted daily checks to ensure the fridge temperature was within range and used a data logging device which alerted management if the temperature was out of range. Fridge temperatures were routinely monitored by the practice management. The practice previously had a fridge in the lead GP's consultation room but this had been decommissioned following a significant event in June 2021. No vaccines were stored in the fridge at the time of the significant event.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 11 November 2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 11 November 2020	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> There were no actions identified in the health and safety risk assessment completed by an external company in November 2020. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> At our previous inspection in March 2020, we found that the practice had carried out a limited audit in relation to infection prevention and control and that actions had been identified but not acted on. At this inspection, we found that the practice had improved its systems for infection prevention and control. During our site visit we observed sharps bins in some clinical rooms which had not been signed and dated when assembled. 	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At our previous inspection in March 2020, we identified that the practice had not provided Sepsis training for staff members. We identified that staff members were not able to tell us about Sepsis and give examples of suitable actions to be taken when an unwell patient was identified. At this inspection, we found that all staff, whether clinical or non clinical, had completed sepsis training. Staff members we spoke to were aware of what action to take in the event of a medical emergency and were aware of how to raise an alarm. The practice had a medical emergencies policy for staff to refer to. There were posters on the premises regarding sepsis, anaphylaxis, safeguarding (both adults and children), chaperones (in multiple languages), personal protective equipment and hand hygiene. 	

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.	Partial
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y

There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> At our previous inspection in March 2020, we found that there was an incomplete system for monitoring the management of two-week wait referrals and could not be reassured that delays in referrals would be picked up by the practice. At this inspection, we saw evidence that a log was kept of all two week wait referrals. We were told that the practice conducted meetings every two weeks to review the log and detect any delays. The practice contacted patients in the event of any delay. The practice did not currently have a member of staff to summarise patient records. The practice had a backlog of 1380 (32.8%) of patient records that had not been fully summarised. The practice had a failsafe policy and systems in place to ensure that results were followed up in a timely manner. For example, the practice conducted a monthly audit in the first week of the month to check that results had been received and actioned where required. 	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.39	0.49	0.69	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). (01/07/2020 to 30/06/2021) (NHSBSA)	10.8%	10.8%	10.0%	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 (01/01/2021 to 30/06/2021) (NHSBSA)	9.42	5.60	5.38	Significant Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) <small>(NHSBSA)</small>	57.3‰	58.1‰	126.0‰	Tending towards variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) <small>(NHSBSA)</small>	1.68	0.50	0.65	Variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2020 to 31/03/2021) <small>(NHSBSA)</small>	6.8‰	4.8‰	6.8‰	No statistical variation

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

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

Medicines management	Y/N/Partial
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We found at our previous inspection in March 2020 that the practice did not have a clear or well documented system for monitoring the stock and expiry dates of emergency medicines. We also did not see documentation to support checking of the defibrillator. • At this inspection, we found that emergency medicines on site were organised, in date, and effectively managed. We saw evidence of emergency medicines stock being checked routinely in a computerised log and heard evidence that the practice manager, and deputy practice manager in their absence, checked emergency medicines stock on a regular basis. There was an electronic system in place since January 2020 whereby expiry dates were entered and management received an alert before the emergency medicine was due to expire. Nursing staff also told us that they checked emergency medicines stock on a monthly basis. • At this inspection, we found: • Whilst monitoring was completed appropriately for some medicines requiring ongoing monitoring (Mirebegron and Spironolactone), there were issues identified in relation to the monitoring of Lithium prescribing. One patient had been prescribed Lithium who lived abroad, however the practice confirmed that it had reviewed recent blood tests sent by the patient. Two patients had been issued prescriptions for three and four months supply respectively. The practice confirmed that both patients had been on Lithium long term and were assessed to be stable. • We found that medication reviews were not always completed in detail in the medical records.. We identified that reviews of learning disability patients and palliative care patients were not always completed in detail. • Blank prescriptions were kept in a locked cupboard and allocated to clinicians each shift and returned at the end of the shift. The practice did not keep a log of the blank prescriptions handed out. The practice confirmed that it would review this process. 	

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:	5
Number of events that required action:	5
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had an up to date significant events policy and recorded significant events centrally in a log which set out the actions required. Staff members we spoke were able to tell us about how to escalate incidents to management. We saw evidence that significant events were discussed in staff meetings. During the Covid-19 pandemic, the staff had 'huddles', which were informal meetings on a regular basis where information was communicated. 	

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

Event	Specific action taken
Delayed urgent ultrasound referral	Document management process reviewed. All reports received by email were to be printed and given to the GP for review before scanning. Electronic documents forwarded to GP for review.
Cold chain disruption in vaccine fridge Temperature above 8 degrees Celsius for a total of 16 hours. No vaccines stored in fridge at the time. HbA1c cartridges stored in fridge.	Practice checked whether the integrity of the HbA1c cartridges would have been affected and these were able to be safely transferred to an alternative fridge. The fridge temperature was monitored for a few weeks before further use and subsequently monitored daily in line with cold chain protocol.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • At our previous inspection in March 2020, we identified concerns with the practice safety alerts process and could not be assured that clinicians were receiving all up to date clinical updates. • At this inspection, we found the system for managing and acting on Medicines and Healthcare Products Regulatory Agency (MHRA) alerts was not always effective: <ul style="list-style-type: none"> - We found one patient on the combination of Simvastatin 40mg and Amlodipine since August 2019 (their last medication review was January 2019). The effect of the combination of these medicines was an increased risk of myopathy and/ or rhabdomyolysis. - We found one patient who was prescribed Citalopram over the age of 65, which was not detected at their last medication review in January 2019. The effect of Citalopram in over 65 year old patients was an increased risk of cardiac arrhythmia. - We also found one patient on teratogenic medicine at childbearing age who had not had the risks of pregnancy discussed with them by their GP. The risks associated with this medicine and pregnancy was foetal abnormalities. • The practice kept a computerised log of all patient safety alerts. The clinicians and practice manager were all signed up to the Central Alerting System (CAS), a web-based cascading system for issuing patient safety alerts. The practice has an up to date safety alerts protocol. When an alert was received, the practice manager would access the system and review the alert and disseminate as appropriate. The practice manager, in conjunction with the clinical lead, would undertake clinical system searches and action where required. The practice confirmed that in the immediate future management of the alerts would be completed with the clinical pharmacist, who was due start imminently. We saw evidence that alerts were discussed at practice meetings where appropriate and if a staff member was not in attendance, they would be forwarded the meeting minutes. • Since the previous inspection, the practice had implemented systems to share safety alerts with the team and carry out any relevant searches. The practice confirmed that in the immediate future management of the alerts would be completed with the clinical pharmacist, who was due start imminently. However, we identified several cases where the practice was not prescribing medicines in line with published safety alerts, for example, combinations of certain medicines where there was the risk of negative interactions or medicines where there is a known risk if they are taken during pregnancy. 	

Effective

Rating: Requires improvement

At our previous inspection in March 2020, we rated the practice as requires improvement for providing effective services because:

- We could not be assured that clinicians were receiving all up to date clinical updates.
- The practice had not met the minimum 90% target for four childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of the childhood immunisation uptake indicators.
- The practice had failed to ensure that persons employed had received appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular:
 - Staff had not been given any training in Sepsis and clinical staff had not completed Mental Capacity Act training.
 - Both GP partners had not completed safeguarding training at Level 3 in Adults.
 - The healthcare assistant had not completed her Care certificate as recommended by Health Education England.

At this inspection, we rated the practice as requires improvement because:

- Patient treatment was not always regularly reviewed and updated.
- The practice had not met the minimum 80% uptake for all five of the childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all five of the childhood immunisation uptake indicators. The practice was working to improve the uptake of childhood immunisation.
- The practice's uptake for cervical screening remained below the 80% coverage target for the national screening programme.

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.	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
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Explanation of any answers and additional evidence:

- We found issues with the management of medicines and the following of clinical guidance. In particular:
- Medication reviews were not always completed in detail in the medical records. In particular, coded reviews did not always consider all the medicines a patient was prescribed, problem codes were not present on the records, blood test monitoring was overdue and there was a lack of documentation.
- Learning disability and palliative care reviews were not always completed in detail.

Older people

Population group rating: Good

Findings

- The practice prioritised visits for elderly patients who were housebound and responded to their needs by arranging regular visits, annual reviews and medication reviews to reduce polypharmacy.
- The practice maintained a register of housebound patients which was read coded to identify patients who required community service for flu vaccination, medication review and chronic disease monitoring. The practice discussed housebound patients at multidisciplinary (MDT) meetings to make joint decisions regarding care. Attendees at the MDT meetings included the community pharmacist, district nurses, safeguarding lead and social services. The practice acted frequently as patient advocate when liaising with social services.
- The practice worked closely with My Care My Way, an integrated care service.
- During the Covid-19 pandemic, the practice had regular meetings to discuss shielding patients and worked alongside social prescribers and My Care My Way to follow up on patients in need of assistance in managing daily activity such as assessing medication and basic supplies.
- The practice took part in Care Hub multidisciplinary team meetings, commencing in September 2020. This involved surgeries sharing best practice in managing older patients in discussion with a geriatrician.

People with long-term conditions

Population group rating: Requires improvement

Findings

- We found issues with the management of medicines for long term conditions and the following of clinical guidance.
- The practice offered longer appointments where clinic or individual needs required.
- The practice reviewed QOF registers and recalled patients where required.
- There was close liaison between the practice nurse and doctors on an ad hoc basis for immediate decisions on care.
- The practice engaged with the CCG Out of Hospital service which provided training, resources and equipment to perform special investigations at primary care level, which improved diagnostic and disease management. For example, ambulatory blood pressure monitoring, electrocardiogram (ECG) and spirometry services within the surgery.
- The practice took part in Directed Enhanced Service (DES), Local Enhanced Service (LES) and Primary Medical Service Clinical Improvement (PMS CI) locally. The additional services included weight management, long Covid-19, clinically extremely vulnerable (CEV) patients under 65, patients difficult to contact, diabetes group consultations via the Primary Care Network (PCN), Last phase of life, advanced asthma, access to general practice (offering 100 appointments/ 100 patients per week), support for carers and care hub MDTs.
- During Covid-19, the practice used an interim respiratory service via the National Institute for Health Improvement. Respiratory nurses contact two thirds of patients on the practice's asthma and COPD registers. The patients had a detailed assessment on the telephone or via video call and symptom review, diagnosis, treatment and patient education. The information was sent to the practice and coded and actioned by the senior administrative team and clinicians.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	77.2%	76.9%	76.6%	No statistical variation
PCA* rate (number of PCAs).	0.8% (1)	7.6%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the	78.4%	90.1%	89.4%	No statistical variation

Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>				
PCA rate (number of PCAs).	22.9% (11)	9.4%	12.7%	N/A

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

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	92.3%	83.4%	82.0%	Tending towards variation (positive)
PCA* rate (number of PCAs).	5.5% (3)	4.2%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	56.3%	66.7%	66.9%	No statistical variation
PCA rate (number of PCAs).	9.2% (13)	12.9%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	80.6%	73.7%	72.4%	No statistical variation
PCA rate (number of PCAs).	6.3% (21)	6.3%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) <small>(QOF)</small>	100.0%	90.5%	91.8%	Variation (positive)
PCA rate (number of PCAs).	15.2% (5)	5.6%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	86.7%	76.4%	75.9%	Tending towards variation (positive)
PCA rate (number of PCAs).	4.3% (6)	8.7%	10.4%	N/A

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

Families, children and young people

Population group rating: Requires improvement

Findings

- The practice had not met the minimum 80% uptake for all five of the childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all five of the childhood immunisation uptake indicators.
- During the Covid-19 pandemic, the practice invited younger patients to talks hosted locally as information sessions regarding the benefits and evidence base for the Covid-19 vaccination.
- The practice identified vulnerable families and offered them longer appointments with the whole family unit. The families were discussed at the clinical meetings.
- The practice offered extended hours on a Tuesday evening until 8:30pm to allow younger patients to access services outside of school and working hours.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	19	25	76.0%	Below 80% uptake
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	12	23	52.2%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	13	23	56.5%	Below 80% uptake
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	13	23	56.5%	Below 80% uptake
The percentage of children aged 5 who have received immunisation for measles,	19	28	67.9%	Below 80% uptake

mumps and rubella (two doses of MMR)
(01/04/2019 to 31/03/2020) (NHS England)

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 our site visit, the practice provided us with information from the National Health Application and Infrastructure Services (NHAIS) system which captured that vaccinations administered by the practice to all children up to the age of two were:
 - 70% uptake for July to September 2020
 - An improvement to 90% uptake from October to December 2020

The practice further provided us with information after running a search for immunisations administered by the practice to three to five year olds on the medical records system. The information captured showed a 62% uptake from January to March 2021 and 64% from October 2021.

- The practice nurse led the childhood immunisation and cervical screening programmes and contacted parents or guardians of children due to have childhood immunisations by text message, telephone and letter and repeated the process if no response was received. There were arrangements in place for following up failed attendances of children's appointments following an appointment in secondary care or for immunisations and escalation to the GP where required. Decisions by parents to decline immunisations were recorded in the medical records. The practice nurse liaised with health visitors where necessary, however this had been restricted during the Covid-19 pandemic. The practice told us that some of its practice population accessed childhood immunisations abroad and that it requested the record of these immunisations.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

- The practice conducted medication reviews, however, we found that these were not always completed in detail in the medication records. We found that coded reviews did not always consider all the medicines a patient was prescribed, problem codes were not present on the records, blood test monitoring was overdue and there was a lack of documentation.
- The practice offered telephone consultation, patient online to book appointments and the ability to order repeat prescriptions.
- The practice operated extended hours surgery from 6:30pm to 8:30pm every Tuesday.
- The practice was proactive in offering NHS health screening. The practice screened over 300 patients in the last year.

- The practice had a duty doctor that triaged calls. The majority of consultations were completed by telephone, and face to face appointments were offered when required.
- The practice offered out of area registration to facilitate patients attending the practice near their place of work.
- The practice had reviewed its cervical screening policy and offered weekly screening with the practice nurse. The practice actively reviewed its screening list and offered appointments at the local hub during the weekend.
- We saw evidence of the practice's performance in the cervical screening recall survey from November 2020. The survey documented that 64.3% of patients had their cervical screening at the practice and 32.1% of patients had their screening conducted abroad or privately. 64.3% of patients understood the importance of attending regular cervical screening and the survey detailed that the practice was planning to send cervical screening information to eligible patients via text message and signpost patient to government information about cervical screening and translated information for Arabic patients.
- The practice had played an active role in the Covid-19 vaccination campaign.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) (Public Health England)	48.6%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	48.1%	62.1%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	41.3%	51.4%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	100.0%	93.5%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	50.0%	57.6%	54.2%	No statistical variation

Any additional evidence or comments

- The practice had a failsafe policy and systems in place to ensure that cervical screening results were followed up in a timely manner. Nursing staff conducted a monthly audit in the first week of the month to check that results had been received and actioned where required. We saw evidence of an audit which had been completed.
- At our site visit, the practice provided us with information on cervical screening after running a search on the medical records system for 2 September 2019 to 2 September 2020 and 2 September 2020 to 2 September 2021. The search showed that more cervical smear tests had been completed in the year 2 September 2020 to 2 September 2021. The practice had demonstrated that it had started to improve on the uptake of cervical screening.

Findings

- We found that reviews for learning disability and palliative care patients were not always completed in detail in the medical records.
- There was a process in place for do not attempt cardiopulmonary resuscitation (DNACPR) decisions and we found one patient who had been coded but the relevant form had not been completed.
- The practice had a register of patients whose circumstances may make them vulnerable, including:
 - People with learning disorders
 - People with poor mental health
 - People with dementia
 - Older people with issues of frailty, multiple co-morbidities and/ or polypharmacy needs
 - People with low levels of literacy in their native language
 - People in institutionalised care settings
 - Those experiencing domestic abuse and family violence
 - Substance abusers
 - Homeless people
 - Sexually active young people
 - Young children, especially those affected by any of the other issues listed
 - Women and girls who were at risk of FGM
 - Marginalised and/ or indigenous populations within nations
 - People subject to persecution within their countries
 - People in fragile, conflict affected states
 - Carers
- The practice held registers of vulnerable children and adults and reviewed patients at multidisciplinary team meetings. Members of the team had completed PREVENT training and all members of staff at the practice had completed adult and child safeguarding training.
- The practice received a bronze certificate awarded by Pride in Practice LGBTQ Foundation for undergoing LGBTQ awareness training in the practice.
- The practice reviewed its learning disorder register and received good feedback from carers.
- During the Covid-19 pandemic, the practice played an active role in vaccinating vulnerable older patients in homes.
- The practice reviewed its demographic patient data and updated ethnicity and spoken first language for 15 to 30% of its population. The practice made sure that these patients had access to translation services.

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

Population group rating: Good

Findings

- The practice reviewed patients with mental health issues as part of its QOF and out of hospital services. The practice engaged with the out of hospital service and recently audited its care of patient with mental health issues. It used a dashboard developed by the local CCG.
- Patients were given access to longer appointments where necessary.
- The practice offered annual health checks to all mental health patients. Nursing staff told us that they would escalate any concerns to the clinicians.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	94.6%	85.3%	85.4%	No statistical variation
PCA* rate (number of PCAs).	7.5% (3)	10.0%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	90.0%	82.6%	81.4%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	5.5%	8.0%	N/A

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

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.

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	531.8	533.9
Overall QOF score (as a percentage of maximum)	95.1%	95.5%
Overall QOF PCA reporting (all domains)	4.7%	5.9%

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

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

- Therapy review of Osteoporosis and Calcium and Vitamin D
Completed 26 November 2020
The aim of the review was to identify patients at risk of calcium and vitamin D deficiency who may benefit from supplementation and to ensure that prescribing of calcium and vitamin D was in line with recommended national and local guidance. The practice used an NHS medicines optimization framework to conduct the audit.
The review noted that calcium and vitamin D3 deficiency was an important factor in the development of osteoporosis and decreased bone density. The practice reviewed 718 patients and identified a proportion of patients who had not been prescribed supplementary vitamins. The finds were discussed with the clinican team and will be repeated to monitor improvement.
- High risk medicines management audit
A review was conducted in June 2021 focusing on reducing medicines related harm. The review identified patients in the following groups: patients prescribed Warfarin with no international normalised ration (INR) recorded within 12 weeks (five patients); patients prescribed Digoxin with no glomerular filtration rate (GFR) less than 45ml/min within 15m (five patients); patients prescribed a combined hormonal contraception (CHC) with a current smoking read code, or no computer recorded smoking status (two patients); and patients aged 18 years and over, non-steroidal anti-inflammatory drugs (NSAIDs), a Renin-angiotensin-system (RAS) drug and a diuretic (two patients) The review identified a number of actions to be discussed with clinicians.

- Vitamin B audit (forwarded by the practice following the site visit)
Review of Vitamin B compound preparation in line with Regional Medicines Optimisation Group guidance
The aim of the review was to reduce prescribing by 80% (items).
First Audit Cycle: September 2020. All patients with a repeat prescription of Vitamin B were reviewed and discussed with their GP by the Clinical Pharmacist. Patients were discussed regarding the latest guidance for the use of Vitamin B with an aim to stop repeat prescribing. 25 patients were identified.
Second Audit Cycle: June 2021. Nine patients were identified on a repeat prescription of Vitamin B. All patients had a range of chronic long term conditions, COPD, Cardiovascular diseases (CVD) and Diabetes mellitus (DM) with a history of alcohol abuse. Clinical Pharmacist would review the patients over the following six months with a view to stop repeat prescribing of Vitamin B.
- Two week wait audit
The practice regularly audited its referrals of urgent 'two-week wait' referrals. The practice informed us that the two week wait spreadsheet log was reviewed every fortnight at a meeting to detect any delays.
- Cervical smear audit
We had sight of a cervical smear audit (from 1 September 2020) which documented patients and their results and recall, including if they had been referred for Colposcopy.

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.	Partial
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> <ul style="list-style-type: none"> • The practice encouraged staff to undertake learning. Some staff members told us that they were given protected time for training and some told us that they completed the training in their own time agreed with management. • Staff appraisals were due, after being delayed due to the Covid-19 pandemic. • The advanced nurse practitioner had informal supervision from the lead GP with respect to prescribing and consultations. The informal supervision sessions were not documented. • We were told that the practice had carried out an audit of the advanced nurse practitioner's prescribing but the practice did not provide a copy for this inspection. 	

Coordinating care and treatment

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

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

Helping patients to live healthier lives

Staff were 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"> The practice told us how patients were referred to other services, for example, the health visitor, social services and social prescriber. The practice used a funded interim respiratory service during the Covid-19 pandemic to review asthma and COPD registers, which reviewed diagnosis, acute and chronic management and patient education via video or telephone consultations with a respiratory nurse. The practice joined the national Covid-19 vaccination campaign and supported the PCN by contributing vaccinators and management staff at the local vaccine centre. The practice delivered Covid-19 vaccinations to housebound patients and worked with the CCG to manage vaccination booking at the local hub. The practice too part in enhanced services including diabetes management group consultations, weight management and long Covid. 	

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.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• There was a process in place for DNACPR decisions and we found one patient who had been coded but the relevant form had not been completed. The practice confirmed that it would run a search to ensure that all patients with a DNACPR code had a corresponding form/ remove the code if this was not appropriate.	

Well-led

Rating: Requires improvement

At our previous inspection in March 2020, we rated the practice as requires improvement for providing effective services because:

- The practice had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:
 - The two week wait referrals for cancer treatment were not tracked once an appointment had been made.
 - Safety alerts were not distributed to members of staff in a coordinated manner within the practice.
 - The practice was only able to produce limited evidence in the safe management of emergency medicines and the frequency of when they were checked.
- The practice had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.

At this inspection, we found that the practice had addressed most of the issues identified at the previous inspection. However we found the following areas where improvement was required:

- The practice did not maintain an accurate record in respect of each patient. Medication reviews were not always completed in detail in the medical records.
- The practice was not always managing prescribing and associated monitoring in line with guidelines.

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">• At our previous inspection, we found that whilst the practice could identify challenges, there were some instances where the practice action plans were limited. For example, childhood immunisations were found to be low and the practice did not have a formalised action plan to improve uptake.• At this inspection, whilst the practice had not met the minimum 90% target for four of the childhood immunisation uptake indicators/ the WHO based national target of 95%, we did see evidence of an improvement in uptake for immunisations of children under the age of two in January 2021. The practice nurse was working to improve the uptake of childhood immunisations.	

- The practice had reviewed its cervical screening provision and performance. It had a failsafe policy in place to ensure that cervical screening results were followed up in a timely manner and conducted audits monthly. We saw evidence that there had been an improvement in the number of cervical smear tests completed in the year 2 September 2020 to 2 September 2021.
- The practice had worked on a succession plan to ensure continuity for future changes brought by retirement of members of the clinical team.

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
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"> • The practice had a mission statement which included the vision of enhancing the health, well-being and lives of those cared for. This also included providing patients with high quality, accessible care in a safe, responsive and courteous manner. Staff members that we spoke to were able to evidence their understanding of the practice's mission statement and their role in achieving this. 	

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's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We received information from the Patient Participation Group (PPG) that the practice was open, sympathetic and helpful, although it had been difficult to meet as a group during the Covid-19 pandemic. They commended that the practice had made its best efforts for patients during under very difficult circumstances. 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. 	

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

Source	Feedback
Staff interviews	All staff we interviewed spoke positively about their employment at the practice. Staff members stated that they felt that managers and clinicians were supportive and that they could raise issues with them.

Governance arrangements

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

	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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> At our previous inspection we found that the practice could not demonstrate that all practice policies were regularly reviewed and updated as required. We found that there was an absence of communication within the management team. At this inspection we found that policies were regularly reviewed and were up to date. We found that there was good communication within the management team and that there was effective management in place for managing infection and prevention control, emergency medicine, emergency equipment and staff and training records. The practice had a governance framework, however it was not always effectively managing risks. These included risks associated with prescribing medicines that required ongoing monitoring and reviewing patients prescribed repeat or multiple medicines in line with guidelines. There was a process in place for DNACPR decisions and we found one patient who had been coded but the relevant form had not been completed. The practice confirmed that it would run a search to ensure that all patients with a DNACPR code had a corresponding form/ remove the code if this was not appropriate. 	

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.	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.	Y
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:	

- We found that the practice was not always keeping accurate or comprehensive clinical records. In particular, medication reviews were not always completed in detail in the medical records. Coded reviews did not always consider all the medicines a patient was prescribed, problem codes were not present on the records, blood test monitoring was overdue and there was a lack of documentation. We were not assured that there were processes in place for reviewing medicines before prescribing. We also found that reviews of learning disability patients and palliative care patients were not always completed in detail.
- The practice had eight outstanding actions identified during the fire, disability access and legionella risk assessments carried out in November 2020. The action plan forwarded following our site visit did not state a date for completion or details of the person responsible for completing the action. Action had been taken with regard to installing a hearing loop and signage about this facility and monthly checks on hot water temperatures.

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

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

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y

Staff whose responsibilities included making statutory notifications understood what this entails.	Y
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Governance and oversight of remote services

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

Engagement with patients, the public, staff and external partners

The practice involved 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

Feedback from Patient Participation Group.

Feedback
<p>The PPG had been unable to meet due to the Covid-19 pandemic.</p> <p>A member of the PPG told us that the practice was sympathetic and helpful when the group did meet and that they felt valued. They told us that the services offered met the needs of the patient population groups and that the practice had made its best efforts during very difficult circumstances.</p>

Continuous improvement and innovation

There was some evidence of systems and processes for learning, continuous improvement and innovation but improvements were required.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Staff at the practice were encouraged and supported to undertake training. The healthcare assistant had recently completed the Care Certificate training. The practice shared learning from significant events and complaints and made improvements as a result of lessons learned. 	

Examples of continuous learning and improvement

- The practice had a programme of structured clinical audits.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease.
- **PHE**: Public Health England.
- **QOF**: Quality and Outcomes Framework.
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ***PCA**: Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- ‰ = per thousand.