

Care Quality Commission

Inspection Evidence Table

Bakersfield Medical Centre (1-547331315)

Inspection date: 07 June 2022

Date of data download: 27 May 2022

Overall rating: Requires Improvement

We have rated Bakersfield Medical Centre overall as Requires Improvement because:

- The practices systems and processes did not always keep people safe.
- Risk to patients' staff and visitors were not always assessed, monitored or managed effectively.
- The arrangement for managing medicines did not always keep people safe.
- There was not always effective processes and systems to support good governance.
- The practices processes for managing risks, issues and performance were not effective.

Safe

Rating: Inadequate

We have rated the practice as in inadequate for the provision of safe services. This was due to

- Risks associated with repeat prescribing.
- Poor management of care information and task management issues.
- Insufficient assurance around training and vaccination status of staff.
- Poor oversight of the property and maintenance including fire, legionella and infection control.

Safety systems and processes

The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes

Safeguarding	Y/N/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.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We were told by management and staff that children who were not brought to appointments were reviewed, coded onto the system and contacted. However, on reviewing of the clinical system we found patients who had not been reviewed, or coded following a missed appointment within secondary services. Most staff were aware of safeguarding procedures and had completed level three safeguarding training. We saw an example of a circumstance where a safeguarding referral should have been considered, the practice had not recognised the potential safeguarding concern. The practice told us that it held monthly multidisciplinary team meetings with the health visitor and district nurses to discuss patients on the safeguarding register. No checks were made on child patients who attended the practice for a non-therapeutic male circumcision procedure to ensure that they were not subject to child safeguarding. We were informed by the practice that non-English speaking patients were on occasions encouraged by staff to attend with friends or relatives to act as translators during appointments with clinicians. There was a risk that patients may have consultations without the ability to disclose personal information or other concerns to clinicians, such as reporting abuse or not consenting. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We examined four recruitment files and found that not all staff had received an appropriate induction or training for their role. For example, the induction procedure for clinical staff did not include the care certificate standards. The standards outline what health and social care workers should know and be able to deliver. We requested but were not provided with confirmation of indemnity insurance for a GP. We examined four recruitment files and found they did not include adequate checks of staff vaccination in line with current UK Health and Security Agency guidance. For example, evidence of staff vaccinations we reviewed included Hepatitis B but did not include a full record of routine immunisations required, for example tetanus, diphtheria, polio and MMR. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Various and ongoing	Partial
There was a fire procedure.	Yes
Date of fire risk assessment: Various and ongoing	Partial

Actions from fire risk assessment were identified and completed.	
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice Legionella policy stated that a Legionella risk assessment from an external provider was required to assess the level of risk. On the day of inspection, we were not provided with an external risk assessment. We were provided with an internal risk assessment that was completed on 04 June 2022 which stated that the overall risk was low. However, the risk assessment did not include assurances around higher risk areas in the building. For example, water tanks, showers and low use taps. Following the inspection, we were provided with a revised risk assessment dated 08 June 2022. We were not assured that the person completing the risk assessment had the necessary knowledge and understanding to undertake this risk assessment. Not all areas of risk were identified. The fire risk assessment did not provide adequate assurances. For example, the risk assessment did not include all areas of the building. We found paper records stored in a room with heat sources which was not included on the assessment. We found areas requiring electrical repair such as light fittings and loose switches which had not been identified on the risk assessment. Following our inspection, we were provided with an updated fire risk assessment with an action plan to fix the electrical repairs in June 2022. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit: 15/03/2022	
The practice had acted on any issues identified in infection prevention and control audits.	No
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> There were system and processes for assessing the risk of, and preventing, detecting and controlling the spread of infections including those that are health care associated. However, we identified areas where appropriate oversight was not in place. For example, cleaning schedule records were not detailed. We found a dirty medical examination light and bins with visible blood stains. Equipment required repairing which was not identified in the infection prevention and control audits for example, a device used for circumcisions required reupholstering and an overhead medical examination light electrics were covered by tape. The practice were responsive to our findings and updated cleaning schedules. We found out of date equipment used for taking patients blood and samples. We were told on the day of inspection that the room was not used for these procedures. The practice were responsive to our findings and disposed of out of date equipment promptly. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial ¹
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.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">¹The practice had an Automated External Defibrillator (AED) but there were no childrens pads for the defibrillator on site. However, a risk assessment was in place in mitigation. The AED had not been tested to ensure the device was safe and working correctly. The practice was responsive to our findings and the equipment was tested the day after our inspection.	

Information to deliver safe care and treatment

Staff did not have 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.	No ¹
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">¹As part of our inspection we viewed the clinical system remotely on 06 June 2022. We found two examples where individual care records were not written in line with current guidance. For example, there was no consultation records following prescription issues in the patient notes.	

- We found 28 outstanding test results awaiting a review by the clinicians. The results dated back to six days prior and we were told the delay in reviewing results was due to the two bank holiday dates. We were told that GPs would review test results and send tasks to the reception team to rebook patients if required.
- The practice advertised services for laser surgery and plastic surgery. The provider told us that this service was no longer offered at the practice. The practice advertised travel vaccinations including yellow fever. However, the practice was not a registered yellow fever centre. We were told on the day of inspection, by the provider that this service was no longer offered at the practice.

Appropriate and safe use of medicines

The practice did not 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) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.66	0.80	0.79	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	4.1%	8.1%	8.8%	Variation (positive)
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 (01/10/2021 to 31/03/2022) (NHSBSA)	4.96	4.61	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	97.2‰	130.0‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.71	0.52	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	4.1‰	6.3‰	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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial ¹
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.	Partial ²
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 ³
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	No ⁴
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
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.	N/A
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Partial ⁵
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> ¹ As part of our inspection we conducted searches on the clinical system of patients who had been recorded with a code as having a medication review. We found that not all patients had received an appropriate review of their medication. This included patients that had outstanding monitoring and no contact had been made with the patients to determine if the medication remained suitable. ¹ On the day of inspection we observed the prescription request process where a patient requested a medication beyond their review date. We were told that the patient would be added to the pharmacists list to conduct a notes review to ensure monitoring was up to date. However, we saw occasions where this had not always happened. ² Letters received from secondary care were managed by the reception and administration team who coded the diagnosis and investigations and sent tasks to the GPs for action. There was no process for oversight of the activity and on the day of inspection we found a patient who had been prescribed an incorrect strength of medication. Following a discussion with the provider a significant event investigation was to commence. 	

- Where hospital letters advised that regular medication was being provided by the secondary care service this was not recorded on the GP clinical system in line with national guidance. This meant that the GP record displayed incomplete information which may be relied upon by future prescribers.
- ³ As part of our inspection we conducted searches on patients taking high risk medications and reviewed records of three patients taking a high-risk drug two patients were not monitored in line with national guidance. We also conducted a search on patients taking direct oral anticoagulants, we found examples of patients who had not been monitored in line with national guidance.
- ⁴As part of our inspection we conducted searches on the clinical system regarding the prescribing of controlled drugs. We found examples of patients who had received frequent issues of drugs outside of national guidance. The clinical record did not include the patient discussion or rationale for prescribing.
- The process for monitoring patients health was not always effective. For example, we identified patients receiving large quantities of asthma inhalers used to relieve symptoms that had not received a review of the frequency of issues of these inhalers. We discussed our findings with the practice. We were told that this was a priority to address and the practice had begun conducting an audit to identify any potential over or under prescribing of Short Acting Beta Agonists.
- ⁵ The temperature monitoring for vaccines was overseen daily using visual checks and a data logger inside the fridge to check the internal temperature was downloaded weekly. We saw regular temperature logs, however, on the day of inspection, we viewed the temperatures of the fridge and found that it showed the vaccines were not stored at the appropriate level in line with the UKHSA guidance and the data logger was not working. Staff responsible for fridge monitoring were not clear on the protocol to be followed to ensure patient safety however, we were assured during the inspection feedback that the correct process had been followed by practice management.

Track record on safety and lessons learned and improvements made

The practice did not always learn and make improvements when things went wrong and there was not an effective system for recording and acting on significant events.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	4
Number of events that required action:	4
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice team completed significant events analysis (SEA) forms which were investigated by the practice manager and GPs. SEA's were discussed in staff meetings. The practice significant event policy described the practice aim which was, to record any incident or situation with the potential to prompt learning or change. However, opportunities to conduct significant events were not always acted upon. We found an example of a safeguarding concern which could have provided action to learn and change which was not investigated. We viewed examples of significant events and found that for more complex events there was not an in-depth analysis and therefore learning opportunities were missed. We viewed examples of significant events in which the learning points, actions required and staff meeting notes were not recorded accurately. 	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Post-operative bleeds following circumcision procedures	Discussed in a staff meeting and the GP researched new techniques to reduce post-operative bleeding. A new method was adopted in November 2021. The practice wrote a review date for August 2022 to review the reduction in post-operative bleeding.
Preprocedural photograph not taken during a procedure. Requested by the hospital following the procedure.	Discussed in a staff meeting with discussion regarding the importance of taking a pre procedural photograph.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	

- We saw examples of actions taken on recent safety alerts and found the practice had ensured patients were contacted and were aware of the risks of taking medications with safety alerts

Effective

Rating: Requires Improvement

We have rated the practice as requires improvement for the effective domain because:

- Patients treatment was not always reviewed and updated.
- Patients were not given information for further help if their condition deteriorated in other language formats.
- Cervical screening rates were below target.
- Childhood vaccination rates were below target.
- Clinical audits did not identify the extent of concerns.
- There was a lack of competency, knowledge and training checks of staff.
- Consent was not always obtained in referrals to other services.

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Partial ¹
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Partial ²
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• ¹As part of our inspection we conducted searches on the practice clinical system regarding prescribing of controlled drugs. We found examples of patients receiving frequent issues of drugs which were not in line with evidence-based guidance. We found examples where patients	

treatment was not appropriately reviewed and updated. For example, we found a patient had been prescribed an incorrect dosage of medication due to a lack of clinical oversight.

- ² As part of our inspection we reviewed processes around the circumcision clinic. Patients were given a post-operative instruction leaflet however this was only in English and other language formats were not available.
- The practice had conducted a significant events analysis from patients experiencing post-operative bleeds and the learning outcome was to improve on verbal post-operative instructions.

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.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check. The practice provided data of the 36 patients eligible of these 94% of patients had received their 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 an underlying medical condition according to the recommended schedule.
- 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.
- Patients with poor mental health were given longer appointments if necessary and referred to the community mental health team located at the premises for assessments and reviews.

Management of people with long term conditions

Findings

As part of our inspection we reviewed the practice clinical system. We carried out searches of patients with long term conditions we found that:

- Our searches revealed five patients out of 224 who had not had the required thyroid function test monitoring for patients with hypothyroidism. We reviewed five records and found four of five patients had alerts of overdue monitoring on the practice system. The administration team had attempted to contact the patient but had not received a response.
- We conducted a search of patients who were invited but had not attended their structured annual review or overdue blood tests. The practice had made no further contact with patients who had failed to cooperate or accept invitations. We spoke with the practice about the findings and were told that the practice would consider implementing a protocol for reducing the duration of prescriptions for patients who do not respond to reasonable drug monitoring requests.
- We conducted a search of clinical records for patients diagnosed with diabetic retinopathy, which is a complication of diabetes, caused by high blood sugar levels that causes damage to the back of the eye. Our searches revealed a total of ten patients out of 388 where blood sugar levels were above acceptable range. Of the records we reviewed, we found several patients who had failed to attend secondary care appointments. However, the practice did not always attempt to encourage compliance or refer on to other services where appropriate.
- We conducted a search for patients diagnosed with stages four or five of chronic kidney disease to check the required monitoring. We found all patients had received the required monitoring in hospital. However, the latest blood pressures were not downloaded which was showing inaccurate alerts on the clinical system. Hospital medicines were also not updated on the practice prescription templates.
- Our searches revealed nine patients taking two or more courses of rescue steroids out of 344 on the asthma register. We reviewed five records and found three patients who had outstanding asthma reviews. We found several patients who, as per NHS guidance required a steroid treatment card, but had not been provided with one.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.

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	31	34	91.2%	Met 90% minimum

type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	42	46	91.3%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	41	46	89.1%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	42	46	91.3%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	54	63	85.7%	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

The practice had reviewed all children who were eligible for vaccinations. The practice expressed difficulties engaging with the practice population. In some cases, there was a refusal of vaccination due to cultural beliefs and language barriers. The practice had delegated a lead staff member to contact patients via telephone and letter. If there was no response the practice would contact the local health visitor to seek additional information such as a change of address or country of residence. To improve uptake of patients with language barriers the practice would contact translation services if required.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	70.1%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	35.4%	64.5%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	65.9%	67.7%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	40.0%	55.7%	55.4%	No statistical variation

Any additional evidence or comments

On the day of inspection we reviewed the practice clinical system and data available and found that the percentage of persons eligible for cervical cancer screening who were screened adequately (within 3.5 years for persons aged 25 to 49) was 67% and (within 5.5 years for persons aged 50-64%) was 79%.

The practice had offered cytology screening throughout the pandemic and was focused on improving uptake by offering appointments with a male or female GP with appointment times throughout the day.

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

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

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

- The practice provided clinical audits. However, the audits did not identify to the extent the concerns CQC identified during the inspection. For example, the practice provided a Tramadol audit from January 2020 which was to establish whether Tramadol was being over prescribed. The practice identified that 49 patients were prescribed appropriate amounts. However, 10 patients required a review of usage for potential over and under usage. There was no action plan to repeat the audit and we saw no evidence of a repeat audit since 2020. We found areas of over prescribing during our clinical searches.
- The practice provided an audit completed in May 2022 following a change of the anaesthetic injection method used during circumcisions from the period of August 2021 to December 2021. The new method was adopted due to six post-operative bleeds that had occurred in patients between January 2021 and August 2021. However, the significant event meeting notes held in November 2021 stated that the change of method would be conducted from November 2021. The audit focused on patients from the month of August 2021 to December 2021 which would not have included the new method of anaesthesia. The audit did not include data from before the change to analyse improvements. The audit found 100% compliance and there was not a second cycle present.
- The practice also provided an audit completed in December 2021 of parental consent for circumcision procedures. The audit stated 150 records had been reviewed. However, no time period had been specified, and the audit did not cover consent in detail. For example, the audit did not consider checks on child identification, checks on parental identification or ages of children. The audit found 100% compliance and there was not a second cycle present.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial ¹
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Partial ²
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial ¹
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial ³
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> ¹During the inspection we found that not all staff had the required training, knowledge and experience to deliver safe and effective care. Following the inspection, we were provided with some evidence of training that had been completed. However, there was a lack of competency checks and oversight of staff knowledge and training. ²There was an induction programme for new staff however, it was focused on recruitment checks rather than a through induction process. The induction did not include the practice protocols and key procedures such as safeguarding. ³ We saw evidence of poor performance and found that there was not always a thorough investigation. However, the practice manager was aware of steps to take to manage poor performance. The practice had not considered the training, skills and competency standards in line with the requirements within the Care Certificate for appropriate staff. 	

Coordinating 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.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes

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.	Partial
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none">As part of our review of the circumcision service we reviewed 20 records. We found that the practice had a good procedure for documenting consent. For example, 19 of the 20 records had completed a parental ID and consent process. Where parents were not present additional checks were made.As part of our inspection we found not all patients had consented to the referral to other services such as secondary care. The practice did not always gain consent of patients to refer to alternative services within the services offered within the primary care network. For example, physiotherapist and social prescriber. Patients were not always given an explanation as to their reason for the referral.As part of our inspection, we reviewed a sample of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions made within the last 12 months. We found that all records were detailed in line with relevant legislation. We spoke with a care home who told us that the practice had appointed a lead GP for the home and involved patients and their families in the decision making and would review DNACPR decisions at regular periods.	

Caring

Rating: Good

We have rated the practice as Good for the caring domain because:

- Staff treated patients with kindness, respect and compassion.
- We received positive feedback from patients during interviews and through share your experience forms directly to the CQC.
- Representatives from care homes spoke positively about the practice.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

Patient feedback	
Source	Feedback
Share your experience forms to the CQC	The CQC received ten positive responses and one mixed response to the share your experience form on the CQC website. The positive responses described the practice team as kind and considerate. The mixed response described some staff as being helpful and polite however, others as being rude and dismissive.
NHS UK	The practice had received two reviews on the NHS UK website in 2021. One review was positive with a patient praising the staff for being helpful and considerate. One review was negative with a patient describing the staff as being unhelpful and receiving a misdiagnosis.
Representatives from care homes	As part of our inspection we spoke with representatives of a care home. The care home reported that the GP practice would call weekly and conduct face to face visits when required and was easy to get through via the telephone. During emergencies or out of hours the lead GP had given a separate telephone line to contact. The care home were complimentary of the care from the practice team including reception and the care home staff and residents felt supported by the practice.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	81.8%	89.2%	89.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	79.4%	88.6%	88.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	92.2%	95.5%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	79.9%	83.7%	83.0%	No statistical variation

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

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence: The practice were able to refer to social prescribers. Social prescribers help patients to improve health, wellbeing and social welfare by connecting them to community services such as wellbeing, weight loss and befriending groups. The practice reception area had posters for local community groups displayed.	

Source	Feedback
Interviews with patients.	On the day of inspection, we spoke with two patients. The patients spoke positively about the practice stating the GPs as being caring and trusting. Patients spoke about the ease of accessing the services by being offered appointments on the same day or the next day.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	93.8%	93.6%	92.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Partial
Information about support groups was available on the practice website.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice used translation services via telephone to translate information to patients if required. The practice team could fluently speak five languages. However, the practice did not have an information leaflet for post-operative instructions in other languages for parents and guardians of children who had been circumcised. We were informed by the practice that non-English speaking patients were on occasions encouraged by staff to attend with friends or relatives to act as translators during appointments with clinicians. There was a risk that patients may have consultations without the ability to disclose personal information or other concerns to clinicians, such as reporting abuse or not consenting 	

Carers	Narrative
Percentage and number of carers identified.	3% total of 168 carers identified.
How the practice supported carers (including young carers).	The practice had an appointed carers champion. The practice would identify carers through the initial registration process or by referral from the GP. The practice would telephone identified carers to ask if they would like a carers leaflet to be sent out. The leaflet had details of the carers support groups available. Prior to the pandemic the practice conducted a carers presentation at the surgery in multiple languages to try to support carers in ethnic minority groups. The practice had plans to hold another meeting by the end of 2022 by inviting the social prescriber and carers hub representatives.
How the practice supported recently bereaved patients.	The practice sent out condolence cards with support information including counselling support.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence:	

The practice had private rooms available upon request if a patient wanted to discuss sensitive issues.

Responsive

Rating: Requires Improvement

We rated the practice as requires improvement for the responsive domain because:

- Changes were required to the complaints literature available to patients to ensure this was accurate and up to date.
- Complaints that were responded to by the practice did not provide details of the Ombudsman if the complainant was unhappy with the practice response.

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.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice tried to ensure that patients were followed up by the GP who saw them at their last consultation.• The facilities and premises were appropriate for the services being delivered however there were outstanding building repairs required. For example, fixing of light fittings and taps.• The premises was accessible via a ramp or steps, the practice told us that blood tests were conducted in a patients car if the patient had poor mobility. However, there was not a risk assessment in place to support this activity.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6:30pm
Tuesday	8am to 6:30pm
Wednesday	8am to 6:30pm
Thursday	8am to 6:30pm
Friday	8am to 6:30pm
Extended access is provided on a Monday until 8:30pm and a Friday morning from 7am where prebookable appointments with the GP are available.	

Monday	8am to 6:30pm
Tuesday	8am to 6:30pm
Wednesday	8am to 6:30pm
Thursday	8am to 6:30pm
Friday	8am to 6:30pm
	8am to 6:30pm

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 was responsive to the needs of older patients during the pandemic and offered Covid-19 vaccinations in their own homes.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional GP appointments were available until 8:30pm on a Monday and 7am on a Friday for school age children so that they did not need to miss school.
- Additional GP appointments were available until 8:30pm on a Monday and 7am on a Friday to support the working age population.
- All parents or guardians calling with concerns about a child were offered a face to face same day appointment when necessary.
- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Late evening and weekend appointments were able to be booked by the practice through the Nottingham City GP Alliance.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
Explanation of any answers and additional evidence: Patients were asked to telephone the practice if they wanted to book an on the day telephone consultation or face to face appointment. The reception team would place patients onto a telephone triage and a timed slot given for a call back from the GP. Patients would be offered a face to face appointment on the same day if required. All children under five were automatically given face to face appointments instead of telephone triage. Where appropriate the GP would signpost patients to alternative services offered at the practice. For example, social prescribers and first contact physiotherapists.	

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	88.1%	N/A	67.6%	Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	77.8%	73.1%	70.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	78.4%	70.0%	67.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	85.1%	82.9%	81.7%	No statistical variation

Any additional evidence or comments

The practice were proud to achieve a higher than average score in the National GP Patient survey for access compared to local practices and the England average.

Source	Feedback
Member of the Patient participation group (PPG)	The PPG were complimentary about access to the service.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care but information available to patients was incorrect.

Complaints	
Number of complaints received in the last year.	6
Number of complaints we examined.	6
Number of complaints we examined that were satisfactorily handled in a timely way.	6
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Partial
There was evidence that complaints were used to drive continuous improvement.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Information was available on the practice complaints procedure. However, we observed that the leaflet sent to patients and the practice policy required updating due to out of date information. For example, there was incorrect details for a complainant who was dissatisfied with the response of the practice. The information given required updating to include the Parliamentary and Health Service Ombudsman. The time limits for a patient wanting to complain to the practice were documented in the policy and leaflet incorrectly. For example, the policy stated a maximum period of six months following the event however the Local Authority Social Services and NHS Complaints (England) Regulations 2009 state complaints can be made within 12 months of the event. Complaints that had been responded to by the practice did not provide details of the Ombudsman if the complainant was unhappy with the practice response. 	

Examples of learning from complaints.

Complaint	Specific action taken
Incorrect information given	Prompt explanation provided to patient with an apology. The practice discussed the complaint in a staff meeting.
Poor customer service	Prompt response provided to patient with an apology. The practice discussed customer service protocols in staff meeting.

Well-led

Rating: Requires Improvement

We rated the practice as requires improvement for the Well-led domain because:

- Leaders could not demonstrate they had the skills to deliver high quality sustainable care.
- Governance processes were ineffective.
- Processes for managing risks were poor.
- There was not always a supportive and open culture.

Leadership capacity and capability

Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Leaders had not identified areas of health and safety, learning opportunities and staff development. Leaders were responsive to our findings however, not all identified areas had the required actions in place to address. For example, following our inspection we were provided with an updated Legionella risk assessment. However, the risk assessment had not been undertaken by an accredited water safety professional and all areas of risk were not identified. In regards to learning opportunities, following our inspection we were provided with significant events from areas of risk that were found during our inspection. The leadership had not identified all areas of concerns and had not taken all necessary actions to address these.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: <p>Due to the pressure of the practice within the last two years, the provider had concentrated on trying to meet the demands of the day to day running of the practice but acknowledged there were gaps in some areas.</p>	

Culture

There was not always a supportive and open culture among leaders and staff

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The management structure of the practice involved members of staff who were related. Staff were aware of the freedom to speak up guardian details who was located at another GP practice. We were told that the leadership team within the practice were not always approachable and receptive to feedback, this had made raising concerns challenging with fear of retribution. 	

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

Source	Feedback
Staff interviews	Staff we spoke with during interviews told us they were happy working at the practice and felt supported within their role.

Governance arrangements

Most governance arrangements were in place, but further work was required.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We found that there was a lack of processes for the practice's governance arrangements which included oversight of correspondence, record keeping, health and safety and updating of policies and procedures. The risks identified during our inspection visit had not been identified through audit or other quality assurance processes. 	

- During our inspection we found policies and procedures that had not been reviewed at the intervals written on the documents. For example, the hand hygiene posters around the practice had a date to be reviewed of 2018 and the practice complaints policy held out of date information.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No ¹
There were processes to manage performance.	No ²
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	No ²
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> ¹ There were insufficient processes for identification of risk, such as audits or reviews of processes based on national guidance. For example, we found risks identified with medication reviews and administrative processes. Risks were not comprehensively understood, for example in relation to legionella and the responsibilities for monitoring risk and escalation. ² Performance of staff was not always monitored for example nonclinical staff had not received supervision over workflow and tasks on the clinical system to reduce risks to patients. Following our inspection, the practice held a significant event meeting and the action required was to complete an analysis of training requirements for staff. 	

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.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes

There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	No
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence: Due to a lack of oversight, correspondence staff were not always acting on patient information appropriately. There was a lack of monitoring in regard to the management of data on patient's clinical notes and letters received from secondary services.	

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.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Following patient feedback, the practice had improved access to the service by offering appointments throughout the day as opposed to morning and afternoon appointments. The new appointment system included lunch time to allow for working age people to attend during their break. Information about the Patient Participation Group (PPG) was available on the practice website and on practice notice boards. This included information on how new members could become involved. After our inspection we were provided with a staff survey that was completed on 08 June 2022. The staff survey was completed by three staff members who reported that they were happy 	

working at the practice and felt supported. There was one response regarding a lack of staff and the practice were actively advertising for an apprentice receptionist.

Feedback from Patient Participation Group.

Feedback

The PPG met with the practice prior to the pandemic on a quartile basis. The last meeting was on 22 January 2020. The PPG chair explained they were in contact with the practice manager and due to arrange a meeting in the summer of 2022. The PPG had appointed a PPG Diabetic Champion, their role was to host a diabetic event to coincide with Diabetes week. Unfortunately, due to the pandemic this was paused. However, the PPG were hopeful to host another event in 2023.

The PPG meetings were attended by the practice manager. The PPG described the practice as being open to feedback.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence: There was limited evidence of effective learning and improvement systems were not comprehensively evaluated.	

Examples of continuous learning and improvement

The practice had used patient feedback to identify improvements required to access and had implemented new appointment times to increase capacity and meet demands.

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.
- **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.