

Inspection Evidence Table

Petroc Group Practice

(1-547484252)

Inspection Date: 7 to 13 June 2023

Date of data download: 04/05/2023

Overall rating: Inadequate

At the last inspection of this service in 2019 we rated the service as good overall. At this inspection we have rated the service as inadequate for the safe and well led key questions and requires improvement for effective and responsive. The caring key question was not inspected and therefore the previous rating of good has been carried forward.

Safe

Rating: Inadequate

At the last inspection in 2019 we rated the practice as good for providing safe services. At this inspection we have rated the practice as inadequate because:

- The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse. There were gaps in systems to assess, monitor and manage risks to patient safety.
- Staff did not always have the information they needed to deliver safe care and treatment.
- There were some delays in processing records.
- The practice had a limited system to learn and make improvements when things went wrong.

However:

- Appropriate standards of cleanliness and hygiene were mostly met.

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.	N
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.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<ul style="list-style-type: none"> • Staff were provided with detailed information and guidance within policies and procedures on how to recognise and take appropriate action when safeguarding concerns were identified. The practice had a safeguarding lead GP. Safeguarding concerns were discussed weekly as part of the clinical practice meetings and staff were aware of how to contact the local authority with any alerts or concerns. • There was no system to enable an oversight of identified safeguarding risks and ensure ongoing monitoring of those risks. There were coded indicators used on the electronic record system to alert staff to patients with a safeguarding risk. . There were no systems to ensure oversight on a regular basis of what was being reported and that any follow up action was carried out. • There was an alert on the electronic records system to inform staff of safeguarded children but the alerting of staff to family members was not consistently used. We requested to see three sets of parent and child records to establish that a coded indicator would inform staff of any risks. This alert system was evident in each of the three children's records. However, for two of the parents' records there was no indication that safeguarding was underway or involved. This meant that parents of vulnerable children were not always evident and therefore staff were not informed of any potential risks. • Training records provided by the practice did not demonstrate that all clinical staff had completed safeguarding level 3 training for adults and children. We saw that 5 clinical staff had not completed safeguarding vulnerable adults training level 3 and 9 clinical staff had not completed safeguarding vulnerable children level 3 training. This is detailed in line with The Adult Safeguarding and the safeguarding children and young people: Roles and Competencies for Health Care Staff August 2018, which states that safeguarding vulnerable adults training level 3 should be undertaken by registered health care staff who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns (as appropriate to role). This includes general practitioners and registered nurses. • We were advised us that DBS checks were completed as part of the recruitment process. However, they were not all available at inspection and so the practice could not demonstrate that all safety checks had been completed. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	N

- The management of recruitment records did not ensure that records were available, audited or provided assurance that appropriate checks had been completed prior to staff employment. The systems in use were being collated and changed from paper records to scanned documents on the IT system.
- We reviewed the personnel folders for 5 members of staff. The recruitment records did not evidence that a consistent approach had been followed when recruiting staff. The documentation did not include all information which is required to meet Regulation 19 and Schedule 3 of the Health and Social Care Act. For example, references and DBS checks were missing from staff recruitment files and for one member of staff there were no records available.
- Records of immunisations were limited, and this meant it could not be identified if staff had appropriate vaccination protection.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	N
Date of last assessment:	Not available
There was a fire procedure.	Y
Date of fire risk assessment:	N
Actions from fire risk assessment were identified and completed.	N
<ul style="list-style-type: none"> • Audits had not been carried out to review the quality and safety of the environment. For example, environmental audits. Some areas of the environment were not consistently monitored and so issues had not been addressed. For example, CCTV was used but signs to inform the public had been removed without staff noticing. • Risk management had not been implemented in line with the providers own policy. Risk assessments had not been completed for the environment, or for specific practices which affected staff. For example, lone working had not been fully risk assessed and plans put in place to minimise any risks. • The practice had a fire risk policy for staff to follow. Fire logs and fire bell tests were completed but a risk assessment had not been completed. There was an arranged appointment with an external company for this to be completed in June 2023. Staff had not all completed mandatory fire training. • The security of the building was a risk, due to a lack of oversight. The management of security of the building was not monitored. We were told all reception staff had an access key to the building. There was no record of who had a key and no policy to inform staff of how the key should be stored securely at their home location. This meant that there was no audit of who potentially had access to the key and building. • All consultation and treatment rooms had been equipped with panic buttons for the use of staff members in the instance of an emergency or dangerous situation with a patient. The alarm would notify the reception desk and enable assistance to be called. 	

Infection prevention and control
Appropriate standards of cleanliness and hygiene were mostly met but with gaps in oversight.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out.	Partial
Date of last infection prevention and control audit:	Unknown
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Y
<ul style="list-style-type: none"> • Staff were provided with policies and procedures which provided guidance and direction on how to manage infection prevention and control (IPC) within the practice. • Cleaning contracts were in place for cleaning both clinical and non-clinical areas. The Petroc Group Practice infection control policy reviewed by the IPC lead on 01 February 2022 stated that, “There will be one infection control audit and one infection prevention and control risk assessment per year”. We requested the audit and assessment from the practice manager and the IPC lead but were advised they could not be electronically sent, an action plan was provided which showed that since 5 April 2023 of the 14 identified actions needed, 3 actions were completed. This action plan did not identify a timescale for completion and ongoing review of the areas which required improvement. • Some areas of the practice did not promote infection prevention and control. For example, some walls and doors required repair and therefore could not be cleaned effectively. • Infection prevention and control training had not been completed by all staff including 5 clinical staff and so we could not be assured that all staff were aware of and followed IPC procedures. • We observed staff took measures to reduce the risk of COVID-19 infection. For patients and staff, alcohol gel was located at the entrance and throughout the building. There was signage reminding people to use the hand gel and wear face masks if they were able to. • Clinical waste storage was available in clinical rooms. Sharps’ boxes were dated and signed when first in use and again when ready for disposal, this enabled an audit trail of their use. Storage of clinical waste was held securely until collected. 	

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.	Y
There was an effective induction system for temporary staff tailored to their role.	Partial
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y

- Staffing levels were planned to ensure there was enough cover for periods of leave such as annual leave or to cover sickness.
- New staff had induction training to support them to work safely. However, there were no consistent records to demonstrate that an induction had been provided and what the induction covered. This meant that there was no audit trail of training to support staff.
- Reception staff had access to a GP if they had concerns about the wellbeing of patients waiting in reception or on a telephone call. There were signage and flow charts to inform staff of actions to take in an emergency. Some staff had completed training in basic life support and how to deal with medical emergencies. For example, if a patient arrived with chest pain, or a child with a head injury, they would immediately alert a clinician and the patient would receive immediate attention.
- The care coordinators taking patient calls were supported by a GP to provide patients with appropriate guidance or care pathways as required.

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment. There were some delays in processing records.

	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.	N
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Partial
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
<ul style="list-style-type: none"> • All new patients who registered with the practice completed a detailed registration form and had a medicines and medical history review. Patients were booked to see a GP or practice nurse if necessary. For example, those patients with a long-term condition or those taking complex medicines. • The management of documents relating to care and treatment was not managed in a timely manner and could place patients at risk. In May 2023 there had been a backlog of 1400 documents waiting for processing. These documents were from external services and included hospital follow up letters and test results. A new member of staff was working through the backlog, but there remained 406 documents awaiting review. Staff explained that some of the documents may have been seen by the doctor and actioned, but they could not guarantee until they were opened and addressed, that all documents had been read and appropriate action taken. Appropriate resources had not been prioritised to meet this backlog and this could place patients at a risk of delayed information and treatment. • The management and oversight of the patients who were referred to an external health provider to be seen urgently (within two weeks) did not include a regular review to identify any delays in receiving the appointments. A log was maintained of all 2-week referral requests, but staff did not routinely check this to ensure that those referrals had been received or had a response. The Petroc Group Practice Referral Protocol 02 May 2023 stated that “Ensure all 2 week wait referrals are sent and logged correctly on the 	

log on W drive. Regularly ensure patients have been seen by checking we have received correspondence”.

There was no system by the practice to follow up with the patient or the hospital to see if the appointment had been actioned. Staff told us that patients were given advice to contact the hospital if they had not received an appointment. We saw that eight 2-week waits had been waiting since 25/05/2023 which exceeded two weeks but there was no record of any update or action taken to follow up and ensure patients had been contacted.

- The management of patients records, when the patient registered with the practice, did not enable records to be accessed easily if needed. The summarisation of these records was undertaken by two members of staff. One staff member worked one day a week and the second staff member worked outside of normal working hours. Staff working at the practice on the day of the inspection, were not clear which records were awaiting summarisation, the prioritisation system and the filing system currently in practice and which records had been waiting for summarisation the longest. The storage system was not clearly catalogued so if records were needed immediately, all records would need to be searched to locate the required records. This may place patients at risk if previously known important medical information could not be accessed quickly.

Appropriate and safe use of medicines

The practice had / did not have systems for the appropriate and safe use of medicines, including medicines optimisation.

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	0.85	0.88	0.86	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). (01/01/2022 to 31/12/2022) (NHSBSA)	7.9%	8.5%	8.1%	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 (01/07/2022 to 31/12/2022) (NHSBSA)	4.84	5.28	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	104.3‰	154.3‰	130.3‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related	0.41	0.61	0.56	No statistical variation

Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)				
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	5.0‰	7.0‰	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.	N
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.	NA
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
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
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	No
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y

- Medicine reviews were undertaken on the birth month of each patient. The reviews were allocated daily between each GP to complete, for example ten reviews each. Staff were not aware if there was a backlog of medicine reviews.
- A procedure was in place for patients who chose not to engage with the review, which included a series of communications such as letter or text message. Once the communications were completed, if the patient did not respond, a decision was made about what further action to take.
- Our remote searches identified that some medicines that required monitoring were being well managed by secondary care services. We reviewed the records of 5 patients prescribed Methotrexate (a medicine used to treat autoimmune diseases such as rheumatoid arthritis) and all were having monitoring arranged via the hospital.
- Petroc Group Practice did not employ non-medical prescribers. Patient Group Directions were used for nurses to administer some medicines. PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber such as a GP or nurse prescriber.
- All medications were stored securely in either lockable refrigerators or a medicine safe. There were logbooks in place to monitor stock levels and usage of medicines.
- The systems to record prescriptions did not ensure an audit trail of their use and would not identify if prescriptions were missing. The blank prescriptions used to prescribe medicines to patients were stored in a secure cupboard. There was a system to record when new prescriptions were loaded into the print trays ready for doctors to use. The first and last serial numbers were recorded as being in use. However, the trays were not secured and were in treatment and consultation rooms used by multiple staff members and patients. Staff confirmed that there was no means to know if any were missing and their use was not audited once they were put into the printer trays. This meant that the safe management of prescriptions was not assured. The practice manager was aware of this risk and had ordered printer tray locks to be fitted to each printer tray. However, no alternative checks had been put in place to mitigate against the risk until the locks were fitted.
- Emergency medicines included an emergency grab bag. The grab bag was located on a corridor cupboard and could be accessible to staff and patients. The bag contained emergency medical equipment including oxygen and emergency medicines. Staff were not aware of the bag, despite an oxygen storage sign on the outer door of the cupboard. We saw emergency medicines were out of date. Three of the medicines including Rectal diazepam (a schedule IV controlled substance) Atropine sulphate (used to treat bradycardia – a slow heart rate) and cyclizine lactate and metoclopramide (used to treat nausea) were out of date for use. For example, one expired in 2021. Staff confirmed that in an emergency, this bag and its contents, could be used. This may place patients at risk of harm and was addressed by the practice staff at the time of inspection.
- The use of antibiotics was not monitored or audited to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y

Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Y
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	N
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<ul style="list-style-type: none"> The practice offered a prescribed medicines delivery service. Systems were used to ensure the traceability of medicines being delivered. The delivery service had not been risk assessed and reviewed to ensure its safe practice. 	

Track record on safety and lessons learned and improvements made.

The practice had a limited system to learn and make improvements when things went wrong.

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.	Y
There was a system for recording and acting on significant events.	partial
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	N
Number of events recorded in last 12 months:	6
Number of events that required action:	6
<ul style="list-style-type: none"> Staff we spoke with were aware of how to raise concerns but there was limited oversight of significant events. We saw there were 6 significant events recorded in the previous 12 months. The practice manager advised that of the 6 significant events, 3 required changes to ways of working. The others required either staff personal reflection, or additional training which we were told had been put in place. There was no evidence recorded that the additional training and personal reflection identified had been completed. There was no recorded evidence that those changes in practice had been implemented and reviewed to ensure they would prevent recurrence of the significant event.. 	

- The records seen did not demonstrate who the significant events were discussed with, how risks were assessed and mitigated, and action logs were not available to record how and who by, action would be taken to ensure a full investigation and prevent recurrence.
- We were told significant events were reviewed and discussed at the clinical meetings and actions agreed to address when necessary. However, the clinical meeting minutes seen did not evidence this was a consistent process, and no other record could be found to demonstrate the actions identified were taken to prevent reoccurrence.
- There were no audits to review themes and trends, and no records of how learning was shared with staff. There was no overview of risks to maintain an oversight and mitigate against future incidents.

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

Event	Specific action taken
There was a delay in referring a patient for an external clinic appointment.	Action noted on the investigation form was 'patient could follow up sooner' which puts the onus on the patient without recognising any issues which may prevent the patient following this up. Other actions included – audit procedure for reports that needed actioning. We were told these follow up procedures had been reviewed and action taken but there was no evidence to support the review and investigation or how this was shared with staff.
An incorrect prescription was given to a patient.	The significant events record noted an action for staff to reflect personally on their prescribing. There was no record that this had been completed by staff. Records did not demonstrate how oversight of prescribing was managed at the practice or any changes made as a result.

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
<ul style="list-style-type: none"> • The practice had systems to receive and act on safety alerts. Alerts and information were disseminated via clinical staff meetings, practice meetings, emails and by discussion. • As part of our remote electronic searches, one patient had been started on SGLT2 inhibitor medicine (This medicine is used to lower blood sugar in adults with type 2 diabetes) and the patient should have received advice about the risk of Fournier's Gangrene (a rare, life-threatening bacterial infection). There was no record of this advice being provided. We spoke with the staff member undertaking that review who confirmed that they would have provided the advice but had omitted to record it. 	

Effective Improvement

Rating: Requires

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.

At the last inspection in 2019 we rated the practice as good for providing effective services. At this inspection we rated the practice as requires improvement because:

- Patients were not all assessed, and care and treatment was not all delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- There was limited monitoring of the outcomes of care and treatment.
- The practice was unable to demonstrate that all staff had the skills, knowledge and experience to carry out their roles.
- The provision of cervical screening for eligible women did not meet national targets.
- Not all processes for supporting staff were formalised and recorded.
- The practice was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

However:

- Staff worked together and with other organisations in an effort to deliver effective care and treatment.
- Staff were consistent and proactive in helping patients to live healthier lives.

Effective needs assessment, care and treatment

Patients were not all assessed, and care and treatment were not all 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.	N
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.	No

There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	No
<ul style="list-style-type: none"> • The practice used National Institute for Health and Care Excellence (NICE) compliance guidelines and any updates or changes in practice were reviewed. This meant that staff should be up to date with changes in good practice. • Patients' treatment for long term conditions were not regularly reviewed and updated. Asthma, diabetes, chronic kidney disease and hypothyroidism reviews were not being consistently identified by the coding systems used. Therefore, the reviews had not been consistently undertaken to ensure all patients with these conditions were fully assessed and reviewed. This could impact on patient's long-term health. • The management of documents relating to care and treatment was not managed in a timely manner and could place patients at risk. These documents were from external services and included hospital follow up letters and test results. Without knowing that all documents had been read and appropriate action taken the provider could not be assured that all patients needs were up to date, regularly reviewed and that any identified care needs were prioritised. 	

Effective care for the practice population

Findings

- For patients with the most complex needs, the GP's worked with other health and care professionals to deliver a coordinated package of care.
- Health checks, including frailty assessments, were offered to patients over 75 years of age. Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients. The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice demonstrated they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice had access to a social prescriber who provided links to services and support agencies in the community.

Management of people with long term conditions

Findings

- Staff who were responsible for reviews of patients with long-term conditions had received specific training. . Patients requiring high dose steroid treatment for severe asthma episodes were seen to be followed up in line with national guidance to ensure they received appropriate care.
- We reviewed five records for patients with chronic kidney disease and saw that those five patients were being monitored by other services.
- Clinical searches showed that 160 of the 1010 patients with diabetic retinopathy had a raised HBA1C above 74 mmol/mol (this is a test to identify the level of blood sugar). We reviewed 5 records, 3 patients had received monitoring, one had been recalled but was not seen and one patient was severely frail, but records did not state why they had not been reviewed.
- During our remote searches feedback and GP interview on 7 June 2023, we supplied the information to the practice about 44 patients who had a potential missed review of their diabetes, for them to review. When we attended the site on the 14th of June 2023, the practice had that day started to look at these 44 patients and by mid-morning had identified 18 patients, who had not been accurately coded and so were missed for recall and review. The nurse undertaking the review of the 44 patients had not reviewed all the patients we had identified but provided assurances this would be completed to ensure effective care and treatment would be provided.
- Patients with long term condition of asthma were not always reviewed to ensure their treatment was optimised in line with national guidance; We reviewed a random sample of 5 records and found that 2 patients had not been invited to have their long-term condition managed in line with recommended guidance.
- Patients being treated for hypothyroidism were not always reviewed to ensure their treatment was optimised in line with national guidance. Remote searches showed that of the 567 patients receiving thyroid replacement, 33 patients had not had the appropriate blood monitoring in the previous 18 months. We reviewed 5 of those patients and 3 had been sent recalls and 2 appeared to no longer be taking the medicine but their notes did not record how this decision had been made.
- An external service had been involved to help the practice complete long term condition reviews. Clinical staff told us this had been very helpful.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenzae type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	137	146	93.8%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received	149	160	93.1%	Met 90% minimum

Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)				
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	150	160	93.8%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	149	160	93.1%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	184	200	92.0%	Met 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>

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	68.6%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	72.8%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (9/30/2022 to 9/30/2022) (UKHSA)	71.3%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	49.2%	55.2%	54.9%	No statistical variation

Any additional evidence or comments

- The practice advised that there had been difficulties encouraging women to attend the practice for cervical screening.
- The percentage of women eligible for cervical cancer screening who were screened adequately within a specified period was 71.3 %, which was below the 80% national target. The practice had screening clinics to meet the shortfall. The practice provided additional data, which was unverified, which identified an increase in screening. However, the practice confirmed this did not currently meet the 80% national target.

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.	Partial
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	N
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	N
<ul style="list-style-type: none"> The practice did not have a planned programme of clinical audits and so did not have an improvement trajectory of any outcomes. However, a small number of local clinical audits had been completed but the outcomes were not evident in changes of practice. The practice did not review admissions and readmissions to hospital to evidence outcomes for patients. 	

Effective staffing

The practice was unable to demonstrate 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
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Partial
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.	Partial
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
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N
<ul style="list-style-type: none"> Staff personal development was supported with staff able to complete online training during work hours. If not possible due to capacity of workload, staff could complete training at home and be paid for this. Induction training was provided for new staff but there was no clear record of the induction training completion for all roles of staff. We saw records which supported administration and reception staff had completed an induction programme relevant to their role. However, records were not available to 	

demonstrate the induction process for clinicians. This meant we could not be assured that they had the right information and support to ensure the safety of patients.

- The provider could not demonstrate that staff had the right qualifications, skills and knowledge to deliver good quality care and treatment. The training records showed that for some staff mandatory training in basic life support, safeguarding vulnerable adults and children, health and safety, moving and handling and infection prevention and control had not been completed or was out of date. For example, not all clinical staff had completed infection prevention and control training and not all staff in the practice had completed fire awareness training.
- Staff in leadership roles had not all completed management training to support them in their roles.
- Clinicians were required to maintain their professional registration and demonstrate their competencies when they revalidated with the relevant professional body. The practice monitored their up-to-date registrations to ensure they were registered to practice.
- Staff found senior management approachable and helpful. There were informal systems for clinical and non-clinical staff to receive support, and any formal supervision was arranged by the clinicians themselves. Not all these processes were recorded.

Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
<ul style="list-style-type: none"> • Clinicians were involved in multi-disciplinary discussion when needed. The practice worked with their internal and external colleagues to ensure patients had access to the appropriate care and treatment was provided. 	

Helping patients to live healthier lives.

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y

Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<ul style="list-style-type: none"> Information was available on the practice website and social media regarding action and support to live healthier lives. Patients with long-term conditions could also access information and support, for example, smoking advice and long-term condition advice. Information regarding health and wellbeing was also provided to patients during health checks and appointments with clinicians. 	

Consent to care and treatment

The practice unable to demonstrate that it 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.	N
<ul style="list-style-type: none"> Our remote search of notes where a DNACPR decision had been recorded identified that only three patients' views had been sought and respected. The practice staff told us that a Treatment Escalation Plan was used instead of the DNACPR document. We requested they search their system to provide us with the required assurance that these were in place. We were not provided with this information and so were not assured that decisions were made in line with current legislation and appropriately recorded. Staff told us they recorded all verbal consent agreed or denied in the patients record. If capacity to give consent was unclear, staff would seek advice and ensure that the appropriate legal route was used to ensure the patients best interest was served. 	

Responsive Improvement

Rating: Requires

At the last inspection in 2019 we rated the practice as good for providing responsive services. At this inspection the practice is rated requires improvement for providing responsive services because:

- People were not always able to access care and treatment in a timely way.
 - Patient satisfaction responses highlighted some issues with accessing services.
 - Complaints were not used to improve the quality of care.
- However:
- The practice organised and delivered services to meet patients' needs.
 - People were able to access care and treatment in a timely way.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<ul style="list-style-type: none"> • The provider had recently made organisational changes to the way patients could access the service. This had been in response to the demand on the service and the needs of the patients. New telephone systems were also planned to improve the delivery of the service to patients. • The provider had considered the needs of the local population and planned services to meet these. The practice could accommodate patients who worked or needed later access. Cervical screening could be arranged out of working hours if needed to enable a better uptake of the service. • The facilities and premises required maintenance to ensure that they were appropriate for use. There was a list of ongoing repairs required. For example, damaged work tops and walls. • A business continuity plan was available which enabled staff to understand the actions to take if the business was interrupted. However, this document required review as it referred to the Health Care Commission which is no longer in operation. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8:30am - 8pm
Tuesday	8:30am - 8pm

Wednesday	8:30am - 8pm
Thursday	8:30am - 8pm
Friday	8:30am - 8pm
Appointments available:	
Monday	9am - 5pm
Tuesday	9am - 5pm
Wednesday	9am - 5pm
Thursday	9am - 5pm
Friday	9am - 5pm

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

- Patients did not have a named GP who supported them in whatever setting they lived. Patients would see whichever GP was available. However, the provider had two locations and two branch surgeries and patients could be seen at any of those locations, offering flexibility for access.
- 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.
- There was a medicines delivery service for housebound patients.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	N
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y

There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<ul style="list-style-type: none"> The surgery was accessible to patients, with ground floor consulting and treatment rooms. The surgery had a website with a range of information for those patients with online access. One theme of complaints was a lack of access to appointments. The practice had implemented an online triage and patient flow system. (The electronic system supported patient triage and flow management with an aim to improve patient access and release GP capacity). This meant patients could request advice and access to appointments with clinicians by completing an online form. On the day of inspection there were 2 care coordinators receiving request forms, and the system was monitored by 2 duty GP's. The system had not yet been audited to establish if it had been responsive in managing demand for appointments. For those patients who did not have access to the digital technology needed, staff were taking the details by telephone. 	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	17.3%	N/A	52.7%	Significant variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	38.2%	63.8%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	37.4%	62.1%	55.2%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	62.0%	78.0%	71.9%	No statistical variation

Any additional evidence or comments

<ul style="list-style-type: none"> The percentage responses to the GP patients survey 2022 showed that 17.3%, compared to the national average of 52.7%, of those who responded found it easy to get through to the GP practice. Since that time a new access system had been implemented. The system is in its infancy but there are plans to audit the responses to ensure it meets the patient's needs.

- The survey showed that 37.4 % of patients consulted were satisfied with the appointment times. This was compared to the national average of 55.2%. It was planned by the practice that the newly implemented access system would address this shortfall.

Listening and learning from concerns and complaints
Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	42
Number of complaints we examined.	10
Number of complaints we examined that were satisfactorily handled in a timely way.	1
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	N
<ul style="list-style-type: none"> The complaints were not audited or reviewed for themes or patterns to prevent reoccurrence. There was no record of how learning was shared with staff to promote changes in practice. For example, we discussed with the practice manager 2 complaints about appointments being cancelled when the practice staff were off sick. The practice manager confirmed that there was no clear policy available for staff to follow to ensure that cancelled appointments were followed up and replaced. This had not been recorded as part of the complaint outcome. This did not demonstrate a systematic approach to managing complaints that could be reviewed, audited and learning obtained and implemented from the process. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient contacted the service to request a diabetic review as they had not been recalled.	It was found that the patient had not been correctly coded as a diabetic and so would not be identified as part of the recall and review process. The patient had emailed several times requesting an appointment without success.
A patient contacted the practice to complain that a referral to secondary care	Once identified the referral was made but no learning or outcomes were identified for the practice.

was not sent and there was a delay in response to the patient.

Well-led

Rating: Inadequate

At the last inspection in 2019 we rated the practice as good for providing well-led. At this inspection the practice was rated inadequate for providing well led services because:

- The practice had a clear vision, but it was not supported by a credible strategy to provide high quality sustainable care.
- The practice culture did not always effectively support high quality sustainable care.
- The overall governance arrangements were ineffective.
- The practice did not always act on appropriate and accurate information.
- The practice did not have clear and effective processes for managing risks, issues and performance.
- The practice had limited involvement with the public, staff and external partners to sustain high quality and sustainable care.

However:

- There was compassionate and inclusive leadership at all levels.
- There were some systems and processes for learning, continuous improvement and innovation.

Leadership capacity and capability

There was compassionate and inclusive 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.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N
<ul style="list-style-type: none"> • Partners held managerial and clinical responsibility for running the business. The provider had not acted to ensure that the CQC registration was up to date and accurate. The inspection process highlighted a lack of understanding by the practice leadership about the legal responsibility to be registered correctly with the CQC. There had not been a registered manager in place since February 2022, the addition of all partners to the certificate had not been done in a timely way and the main partner had not been replaced on the CQC registration certificate. • The providers had management and staffing structures in place, so people understood their roles and responsibilities. Staff were allocated leadership roles which included infection prevention and control, safeguarding and clinical and non-clinical leaders. However, some of these roles were not being fulfilled effectively. • Staff spoke positively about the support they had from colleagues and told us they could speak to GP partners or the practice manager for support when necessary. 	

- Staff appointed into management or leadership roles had not completed appropriate management training and qualifications. This meant that they did not always have the insight or support to be effective.

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.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N
<ul style="list-style-type: none"> • The vision statement of the practice was available for staff and noted on the practice website. Staff were not all aware of the providers vision and did not feel involved in the services vision and strategy development. • There was no recorded management of an ongoing strategy to meet the vision. The ongoing practice development was not reviewed as part of operational meetings and staff appraisals. 	

Culture

The practice culture did not always effectively support 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.	N
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	N
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Partial
<ul style="list-style-type: none"> • Staff told us they liked working at the practice and felt teamwork was a positive strength. • The practice did not have a staff survey or means for staff to feedback their views. The practice manager operated an open-door policy and staff told us they felt able to raise any issues with the practice manager. The practice had access to a Freedom to Speak Up Guardian. 	

- We noted that management training and support had not been provided to ensure complaint and incidents were managed consistently. We saw that when people were affected by things that went wrong, they had not always been given an apology and informed of any resulting action.
- Not all clinical and non-clinical staff had completed equality and diversity training.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	N
<ul style="list-style-type: none"> • Structures, processes and systems to support good governance and management were not consistently followed. The practice did not have governance systems which identified when the service did not respond well. For example: • The practice did not follow its own complaints policy and procedure. Patients did not consistently receive an acknowledgement of their complaint and responses were not timely. The overview of complaints had not led to changes in practice and reoccurring themes could be seen. These included poor staff attitude, failure to respond to patients queries and difficulty in accessing appointments. There was no consistent recording of internal meetings to discuss complaints. Documentation relating to complaints did not always evidence the investigations, actions taken or resulting changes to practice and staff shared learning. • The governance of significant events did not ensure that investigation was thorough, recorded and that outcomes identified had led to changes and improvement in practice. • Systems used to recall and review patients for long term conditions were not overseen and systems used to identify and recall patients had not been consistently followed by staff. Some patients had not had the reviews they needed. • Audits of systems used to ensure patients were kept safe were not completed. For example, the recruitment systems used were incomplete and so could not ensure patient safety. Staff training systems were not overseen to ensure that mandatory training had been completed by all staff. • Administrative systems were not reviewed, and oversight maintained to ensure that workflow of documents was safely managed. 	

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.	N
There were processes to manage performance.	N
There was a quality improvement programme in place.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
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.	N
<ul style="list-style-type: none"> • Risk management was not overseen and so risk assessments were not completed and managed to ensure patients and staff were as safe as they could be. • There was a lack of risk management to include the building, staff members and specific working practices. For example: The practice could not demonstrate that recruitment procedures had been followed so patients and staff were safe. • Risks were not recorded and routinely reviewed to detail the actions to manage and reduce any known risk. For example, there was a lack of risk oversight of maintenance and updating of the premises to ensure they were safe for patients and staff. The Petroc Group Practice Health and Safety Policy Statement (Due for review in February 2024) described the actions the management team should follow to record and manage risks. For example, risk assessments and actions to control risks. We saw the practice did not have these systems in place and did not follow their own policy. • There was no monitoring or any improvement programmes to look at services provided, how the services could be improved, or the impact on the quality and sustainability of the practice. • There were no systems to identify or gather information/data about performance of the practice and no processes to then address any identified issues and so improve the quality of the service. For example, there was no auditing of clinical practices or administrative services to then review any risks or changes needed to the service provided. 	

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.	N
Performance information was used to hold staff and management to account.	N
Staff whose responsibilities included making statutory notifications understood what this entailed.	N
<ul style="list-style-type: none"> • Clinical and non-clinical meetings were not all recorded to provide an audit trail of areas discussed, decisions made and how these decisions would be actioned and followed up. For example, complaints meetings and staff performance management had not been consistently recorded to ensure a clear audit 	

trail. Any risks identified were not monitored on a risk record or register to ensure oversight was maintained.

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y
<ul style="list-style-type: none"> Information was provided for patients on the practice website on how their personal details were stored securely and how their privacy was maintained. The website detailed how personal data was gathered and what that data would be used for. All electronic equipment was password protected and the reception area faced away from service users to protect confidentiality. Patient data was stored securely when it was on-site. 	

Engagement with patients, the public, staff and external partners

The practice had limited involvement with 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.	N
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
<ul style="list-style-type: none"> Patient Participation Groups (PPGs) are made up of volunteers interested in healthcare issues which meet to decide ways and means of making a positive contribution to the services and facilities offered by the surgery to patients. The practice PPG had 5 members and they met on an ad hoc basis. The 	

representative told us their role was considered as a critical friend and that the practice was responsive and engaged with the PPG. The PPG had not surveyed or gathered the views of patients and so had no recent feedback for the practice.

- There was no active survey system to gather the views of patients so they could in turn be used to improve the service.
- There was no staff survey or means to gather the views of staff to help with the planning and delivery of the service.

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> • The PPG did not have a formal process to gather feedback from the patients. Meetings were held and information from patients was shared with the PPG. There were no recent records or assurances available for our review. • The PPG were aware that telephone access was problematic and that working across the practice sites was challenging from a communications perspective.

Continuous improvement and innovation

There were some 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
<ul style="list-style-type: none"> • The PCN social prescriber attached to the practice had been involved in a structured diabetes educational programme, looking at ways to support patients with diabetes. A series of in-house educational sessions had been delivered. The initial results had shown a reduction in the blood sugar levels of some patients. 	

Examples of continuous learning and improvement
<ul style="list-style-type: none"> • The practice had recently implemented a new triage system which involved telephone triage by clinicians and care coordinators. This new system was in its infancy and would be reviewed in the future. A further new telephone system was planned to support patient access to the service. • The practice clinicians had signed up to a local research initiative involving patient groups in clinical trials through local universities and pharmaceutical companies. This initiative was to start in the near future.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	Y/N/Partial ≤ -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.