

Care Quality Commission

Inspection Evidence Table

Battersea Rise Group Practice (1-568377395)

Inspection date: 21 June 2022

Date of data download: 04 May 2022

Overall rating: Good

Safe

Rating: Good

We carried out a focused inspection of Battersea Rise Group Practice on 21 June 2022 and have rated the provider as good overall. Specifically, we found the practice to be good for providing safe, effective, and well led services.

Safety systems and processes

The practice had 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.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Partial
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">- Out of hours were not routinely informed of relevant safeguarding information, however they had access to the practice systems and patient records.	

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.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> - During the inspection, we reviewed the staff folders of five staff members and identified gaps in recruitment systems including missing CV's, missing references, no signed contract or confidentiality policy and no photo ID was seen in the folders. - An induction checklist was seen for one staff member, an appraisal was seen for two members of staff and all five staff folders we reviewed had evidence of a DBS check in their folders. The practice told us that missing documentation in staff folders was due to the length of employment of staff and that the practice no longer held certain documents as the staff members had been working at the practice for several years. - The practice told us that a signed contract was in four of the folders and photo ID was present in three of the five folders reviewed, however we did not see evidence of this during the site visit. All missing documents for one staff folder were seen at the end of the inspection. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Y July 2021
There was a fire procedure. Date of fire risk assessment:	Y Partial February 2019
<p>Actions from fire risk assessment were identified and completed.</p> <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> - Evidence of Portable Appliance Testing (PAT) was seen dated June 2022, however this was not signed by the contractor carrying out the testing as proof of validity. At the end of the inspection the practice provided evidence of a signed PAT testing document. - Hazards identified from the health and safety risk assessment had an action to address the hazard, however the column for completion date and staff initials had not been completed. - The practice provided a separate action plan with the issues identified and the action taken to address them. - An annual health and safety review was also provided dated May 2022 with actions identified and a documented target date of July 2022 for those actions to be addressed. - A fire risk assessment was seen dated February 2019. The practice told us they had a recent fire risk assessment undertaken in May 2022, but they had not yet received the assessment. - At the end of the inspection the practice provided email evidence that a fire risk assessment had been carried out in May 2022 and they had not yet received the assessment back in order to address any actions that may have been identified. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial ¹
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:	12 May 2022
The practice had acted on any issues identified in infection prevention and control audits.	Partial ²
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. The staff training schedule submitted by the practice identified that a member of clinical staff had not completed their infection prevention and control training but noted that the staff member was aware that it needed to be completed and had been on long term leave. 2. Where the infection prevention and control audit identified that action was required, there was no documented review date to confirm that action had been completed on the audit. <ul style="list-style-type: none"> - The practice provided evidence that actions from the infection prevention and control audit had been captured on a different document, called a risk register and most had been addressed. The practice told us that they had applied for grant funding from the CCG to refurbish clinical rooms. - Cleaning standards signage was seen around the practice and a weekly cleaning log was also seen. 	

Risks to patients

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

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

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y

Appropriate and safe use of medicines

The practice had 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) (01/01/2021 to 31/12/2021) (NHS Business Service Authority - NHSBSA)	0.54	0.63	0.76	Tending towards variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2021 to 31/12/2021) (NHSBSA)	14.1%	9.7%	9.2%	Tending towards variation (negative)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2021 to 31/12/2021) (NHSBSA)	6.94	5.47	5.28	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) <small>(NHSBSA)</small>	30.5‰	61.3‰	129.2‰	Significant Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) <small>(NHSBSA)</small>	0.51	0.56	0.62	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) <small>(NHSBSA)</small>	3.5‰	4.7‰	6.8‰	Tending towards variation (positive)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	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.	Partial ¹
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y

Medicines management	Y/N/Partial
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
Explanation of any answers and additional evidence:	
<p>1.</p> <ul style="list-style-type: none"> - There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines with appropriate monitoring and clinical review prior to prescribing. However, clinical searches identified some gaps in patient monitoring with regards to overprescribing and patients taking high risk medicines, which were found to be low risk. - Regarding negative prescribing indicators, the practice told us with that they had a list of quality improvement initiatives that they were working through and had carried out some audits into prescribing which showed improvement. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	8
Number of events that required action:	8

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

Event	Specific action taken
Member of the public entered restricted part of the building.	The event was discussed, and the importance of internal doors being kept closed at all times was highlighted as well as a reminder of the lone working policy.
Delayed referral.	Staff were supporting the Covid vaccine booster programme at the time, more admin staff were employed to support clinicians with their workload.

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> - We saw examples of actions taken on recent alerts for example, regarding the recall of a specific batch of antidepressants. 	

Effective

Rating: Good

We have rated the practice good for providing effective services because although the practice had not met the minimum 90% target for four out of the five childhood immunisation uptake indicators for 2020/21, they had performed better than many of their neighbouring practices and were close to the expected targets. The practice had not met the minimum 80% target for cervical screening for 2021, however they had considered the possible causes for not meeting these targets, were able to tell us about plans to improve uptake and had provided unverified data that showed some improvement. The practice followed a programme of quality improvement and were able to evidence how they prioritised their most clinically vulnerable patients during the pandemic. While gaps in patient monitoring were identified, they were found to be low risk and the practice were able to tell us what actions would be put in place to address concerns effectively.

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, however some gaps in patient monitoring were identified.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> - The practice told us that they prioritised all vulnerable patients during the pandemic and contacted all of them to make sure they had support, including offering appointments with the social prescriber. They also kept a spreadsheet of services that patients could be easily signposted to, including a mental health support worker. 	

Effective care for the practice population

Findings

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

Management of people with long term conditions

Findings

Findings from clinical searches:

Over-prescribing:

- We found no concerns when reviewing searches for patients that had been prescribed more than the recommended number of asthma inhalers over the past 12 months.

Missed diagnosis:

- Our searches identified zero patients as having a potential missed diagnosis of diabetes or chronic kidney disease (CKD) stage 3, 4 or 5.

High risk drug monitoring:

- During the inspection we reviewed the records of five patients taking direct oral anticoagulants (DOACs) (medicines used for the prevention of thrombosis in several cardiovascular contexts) of which three patients were at risk of potential harm. Two patients had not had the required monitoring and one patient was taking a higher dose of medicine than required.
- The practice told us that they would recall the patients for their blood tests and amend the patient's prescription within seven days.
- We reviewed the records of five patients taking angiotensin-converting enzyme (ACE) inhibitor or Angiotensin II receptor blocker (medicines used to treat high blood pressure, and heart and kidney problems) and identified four patients were at risk of potential harm due to the required monitoring not being carried out before they were prescribed medicines.
- During the inspection the practice informed us that these patients had been reviewed and two of the patients had been recently seen and were having their blood tests carried out elsewhere, one of the patients had their prescription stopped and one patient had been invited to have their blood tests done.
- We reviewed the records of patients taking azathioprine (an immunosuppressive medication) and found that these patients were being monitored appropriately.

Long term conditions:

- We identified three patients with hypothyroidism who had not had the required monitoring in the last 18 months, two of which were at risk of potential harm due to no documented monitoring prior to prescribing.
- We reviewed a sample of four patients with asthma who had 2 or more courses of rescue steroids in the last 12 months and found one patient did not have a documented asthma plan, a steroid card and there was insufficient documented justification for the prescribing of medicines.
- We reviewed the records of five patients with diabetic retinopathy with a high blood glucose level and found that these patients were being monitored appropriately.
- We reviewed the records of patients with CKD stages four or five and found that these patients were being monitored appropriately.

Medication reviews:

- We reviewed a sample of patient consultations for medication reviews and found no concerns
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- 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.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	64	71	90.1%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	61	73	83.6%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	61	73	83.6%	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)	62	73	84.9%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR)	87	113	77.0%	Below 80% uptake

(01/04/2020 to 31/03/2021) (NHS England and Improvement)				
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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 told us actions they had taken in relation to childhood immunisation uptake:

- Their call and recall system had improved and patients who did not attend their appointments were sent text messages and called.
- Those patients who still did not respond were escalated to the lead GP who would escalate to the health visitors.
- Patients who had their immunisations done privately were asked for evidence and their notes updated.
- Nurses would speak to parents and try to ease concerns around childhood immunisations.
- Many patients had moved away or return to their home countries as a result of the pandemic.
- They had employed two admin staff to help increase uptake.
- The practice provided unverified data for Apr- Jun 2022 which showed the practice had met and exceeded the 90% minimum target across all indicators.

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)	67.2%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	56.0%	52.4%	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)	67.8%	63.5%	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)	45.5%	52.9%	55.4%	No statistical variation

Any additional evidence or comments

The practice told us action they had taken in relation to cervical screening uptake:

- They put posters up around the practice and had run campaigns specifically targeting young people.

- They practiced opportunistic appointment booking.
- They worked hard to dispel negative perceptions around cervical screening.
- They felt that their invitation process had improved due to employing more admin staff.
- The practice provided unverified data for January 2022 which showed an improvement of 1%.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

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

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

- The practice followed a programme of quality improvement which consisted of both clinical and non-clinical audits.
- The practice had undertaken a cervical screening audit looking at the number of inadequate cervical screening tests carried out and found that they had a very low inadequate cervical screening rate and were able to increase on the amount of screening tests carried out over the past two years despite the pandemic.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y

The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centered care when they moved between services.	Y

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> - The practice participated in the CCG led scheme which encouraged to be involved in monitoring and managing their own health by monitoring their own blood pressure at home. 	

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
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Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y

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	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	Y
There were systems in place to support patients who face communication barriers to access treatment	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

Well-led

Rating: Good

We have rated the practice good for providing well-led services because the practice had identified the challenges they faced in providing high quality care and treatment to patients and had implemented actions to address those challenges. The practice had governance structures and systems in place which were regularly reviewed.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y

They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> - The practice told us that they had identified challenges including workload pressures, unrealistic expectations of staff and a lack of resources but had put together a comprehensive risk register with documented actions to mitigate those challenges. - The practice told us they had a succession plan in place and were in the process of training staff to fill the deputy practice manager role. They also told us they hoped to recruit GP partners in the future and were planning to start student nurse sessions with a view to recruiting additional nurses to the practice. 	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y

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

Source	Feedback
CQC staff questionnaire	Feedback from staff included: <ul style="list-style-type: none"> - Staff felt that the practice were especially good at responding to patient queries promptly. - Staff felt supported by the practice and that it was a team environment. - Staff reported that incidents, significant events and learning were shared with all staff. - They felt leaders in the practice were visible and approachable.

Governance arrangements

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

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

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	

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

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

Appropriate and accurate information

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

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

Governance and oversight of remote services

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

Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Partial
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: - The practice told us that their virtual Patient Participation Group had not been very successful, and they were trying to get physical meetings back up and running. - The practice told us that they collected feedback from various sources including NHS reviews, google reviews and the friends and family test. They discussed feedback at meetings in order to pull out themes and take action to improve them.	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

Examples of continuous learning and improvement

- The practice told us that they were proud of the work they have done to maximise uptake of Covid and flu vaccinations, especially for their patients with a learning disability, and they are also having discussions to make health checks more meaningful for patients.
- The practice told us that they run a monthly paediatric clinic, a service which will soon be available for all patients in their Primary Care Network (PCN).

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.