

Care Quality Commission

Inspection Evidence Table

Lister Medical Centre (1-5996880135)

Inspection date: 12 January 2023

Date of data download: 16 December 2022

Overall rating: Requires improvement

We previously carried out an announced comprehensive inspection at the practice on 6 May 2022. The practice was rated as inadequate overall and placed in special measures. As a result of the concerns identified, we issued three warning notices on 18 May 2022 in relation to breaches of Regulation 12 (safe care and treatment), Regulation 17 (good governance) and Regulation 18 (staffing) setting out areas where the practice was in breach of regulation. This inspection on 12 January was carried out and to follow up on breaches of regulation issued at the last inspection, and to reassess their special measures status.

When we returned to review progress and to assess compliance with the breaches of regulation identified in the warning notices in January 2023, we observed many positive changes and improvements. Some workstreams remained ongoing as part of a longer-term plan to achieve sustainable outcomes, but we saw that a clear plan was in place to achieve this.

The provider submitted evidence of action taken to address the warning notice requirements.

We have rated this practice requires improvement overall. We found two breaches of regulations.

We found that:

- The practice did not always have systems, practices and processes in place to keep people safe and safeguarded from abuse.
- There were appropriate standards of infection control measures and safety systems.
- Staff had been recruited to roles in all areas of the practice, and staffing levels were more stable, but recruitment was ongoing for a number of clinical and non-clinical posts
- Whilst the practice had made improvements to ensure patients ongoing needs were fully assessed and delivered in line with current guidance, we identified, through our clinical searches, that further monitoring was required.
- Childhood immunisation indicators and cervical cancer screening indicators remained below national averages, however the practice had taken measures to increase the uptake and support patient with their decision making.
- There were improvements in system and processes to monitor staff training but there were still gaps in the practice's mandatory training schedule.

- The results from the national patient survey demonstrated were lower than the local and national averages.
- Opportunities to learn from complaints and improve the quality of care required further development and embedding.
- The way the practice was led and managed promoted the delivery of high-quality, person-centre care.

Safe

Rating: Requires Improvement

At the last inspection in May 2022 we rated the practice as inadequate for providing **safe** services. This was because:

- The practice did not have sufficient systems and processes to keep people safe;
- Not all staff had received the appropriate level of safeguarding training;
- Fire risk assessments were not up to date;
- Health and safety risk assessments had not been completed when risk had been identified;
- Appropriate monitoring standards of cleanliness and hygiene were not in place;
- Staff were not equipped to respond to medical emergencies;
- There were delays in the management of referrals and test results;
- Systems for the appropriate and safe use of medicines, including medicines optimisation were not effective;
- The practice did not regularly share learning from incidents with staff;
- The system to receive, review and take appropriate action on Medicines and Healthcare products Regulatory Authority (MHRA) was not effective.

At this follow up comprehensive inspection we carried out remote clinical searches on 10 January 2023 and an onsite inspection on 12 January 2023 in which we spoke to the provider and staff. We were provided with evidence which demonstrated the action taken to develop systems and processes to keep people safe; to ensure patients had received appropriate monitoring and ensure systems to receive, review and take appropriate action had improved.

We have rated this practice requires improvement because:

- Systems, practice and processes to keep people safe and safeguarded from abuse required strengthening. We identified remaining gaps in safeguarding training for staff at appropriate levels for their role.
- The practice had undertaken a successful recruitment campaign, however staffing levels remained below local and national averages.

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse, but these required strengthening.

| Safeguarding | Y/N/Partial |
|---|----------------------|
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Partial ¹ |
| Partners and staff were trained to appropriate levels for their role. | Partial ¹ |
| There was active and appropriate engagement in local safeguarding processes. | Yes |
| The Out of Hours service was informed of relevant safeguarding information. | Yes |
| There were systems to identify vulnerable patients on record. | Yes |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Yes |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Yes ² |
| <p>Explanation of any answers and additional evidence:</p> <p>¹ At our last inspection in May 2022 we found:</p> <ul style="list-style-type: none"> There were gaps in the levels of training for staff appropriate for their roles. <p>At this inspection in January 2023 we found:</p> <ul style="list-style-type: none"> All clinical staff had completed Level 2 safeguarding adults training, three clinical staff had not completed Level 3 adults training. Two clinical members of staff had not completed Level 2 or 3 safeguarding children training. We saw that 1 member of staff had recently joined the practice and was in the process of completing their local induction. However, there were gaps remaining in the level of training for non clinical staff. For example, we identified that non clinical staff, with the exception of staff employed by the local Primary Care Network, had not undertaken Level 2 training; current guidance specifies non clinical staff, who in their role, have contact (however small) with children, young people and or/parents or adults who may pose a risk to children require Level 2 training. During the inspection the provider took action to ensure staff required to undertake this training were identified. We saw that the mandatory training matrix had been updated and staff had been requested to complete this training. All staff had completed PREVENT training in line with national guidance to safeguard and support those most at risk of radicalisation. Staff demonstrated clear awareness of their responsibilities around reporting incidents of suspected concern. The practice had safeguarding policies which were reviewed and staff were aware of how to access these policies and advice from the nominated safeguarding leads. <p>² At our last inspection in May 2022 we found:</p> | |

| Safeguarding | Y/N/Partial |
|---|-------------|
| <ul style="list-style-type: none"> That regular discussions between the practice and specific health and social care professionals had been paused during the COVID-19 pandemic and had not restarted for example, with Health Visitors and School Nurses. <p>At this inspection in January 2023 we found:</p> <ul style="list-style-type: none"> The provider had reinstated safeguarding meetings with external agencies, however external agencies were not always able to attend. External agencies had access to contribute to these meetings. The practice had a plan in place to continue with multidisciplinary meetings and processes has been identified to ensure confidential updates were shared with external agencies. | |

| Recruitment systems | Y/N/Partial |
|--|-------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Yes |
| Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We reviewed three staff files and found that all files contained relevant information. | |

| Safety systems and records | Y/N/Partial |
|--|------------------|
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: | Yes ¹ |
| There was a fire procedure. Date of fire risk assessment: 15 June 2022 | Yes |
| Actions from fire risk assessment were identified and completed. | Yes ² |
| Explanation of any answers and additional evidence: <p>¹ At our last inspection in May 2022 there were shortfalls in safety systems and records which included:</p> <ul style="list-style-type: none"> A health & safety and fire safety audit, dated 5 May 2022, identified four key health and safety policies which were not in place. <p>During our inspection in January 2023 we found:</p> <ul style="list-style-type: none"> Health and safety policies had been reviewed, and detailed responsibilities for both the practice and individual staff were evident. Risk assessment and control forms were in place. Examples seen during the inspection included assessments to monitor the risk of patient information flow due to postal strikes. On the day of the inspection we observed a risk assessment had been completed due to a lighting failure within the building and immediate action had been taken. | |

- A fire risk assessment had been conducted in June 2022. Medium and low priority actions had been identified. Managers told us that there were plans in place to work with the landlords of the building to address outstanding low level actions.
- Fire alarms, extinguishers and smoke alarms were visible, and had been tested.
- Portable appliance testing and equipment calibration was undertaken annually.
- The practice had assessments in place for the safe control of substances hazardous to health (COSHH).

² At our last inspection in May 2022 we found:

- Not all fire marshals had undertaken appropriate training for the role. In addition, there was not a fire risk assessment in place to mitigate the potential risk this presented.

During our inspection in January 2023 we found:

- Fire marshals had received training in June 2022.
- During the inspection we saw signs around the building to identify fire marshals.
- Staff were able to describe actions taken during a recent fire alarm evacuation drill.

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. | Yes |
| Infection prevention and control audits were carried out. | Yes |
| Date of last infection prevention and control audit: 3 May 2022 | |
| The practice had acted on any issues identified in infection prevention and control audits. | Yes |
| The arrangements for managing waste and clinical specimens kept people safe. | Yes |
| Explanation of any answers and additional evidence: | |
| At our last inspection in May 2022 we found: | |
| <ul style="list-style-type: none"> • Nine members of staff had not completed the training and two staff members' training was overdue. In addition, the practice did not have an IPC lead in place. | |
| During our inspection in January 2023 we found: | |
| <ul style="list-style-type: none"> • All staff had undertaken training within the identified two-yearly schedule. • An infection control policy and procedure, November 2022, had been implemented and all staff had access to this document. • A lead clinician responsible for infection control was now in place. An infection prevention control (IPC) nurse had been identified to support this role. The practice manager had been identified as the non-clinical infection control. In addition, the practice had identified an IPC champion to provide additional support. An infection control action plan was in place. • Hand hygiene audits had been undertaken in December 2022. The findings had been presented to staff at team meetings. A re-audit had been conducted in January 2023. | |

- The practice had been supported by commissioners and further work was planned to ensure compliance with the recommended actions of these audits.
- The IPC nurse told us they had been supported to undertake additional training in this role.

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. | Yes ¹ |
| There was an effective induction system for temporary staff tailored to their role. | Yes ² |
| The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures. | Yes ³ |
| Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients. | Yes ⁴ |
| There were enough staff to provide appointments and prevent staff from working excessive hours | Partial ⁵ |
| <p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in May 2022 we found:</p> <ul style="list-style-type: none"> • ¹Staff told us they regularly worked overtime to manage staff absences and to reduce identified backlogs in workload. • ²Induction systems in place for temporary staff were not effective. • ³The practice was not equipped to respond to medical emergencies. • ⁴There were gaps in training in identifying a deteriorating patient for non clinical staff. • ⁵The provider was below local and national averages in clinical workforce levels and there were significant vacancies in clinical and non clinical posts. <p>During our inspection in January 2023 we found:</p> <ul style="list-style-type: none"> • ^{1&5} Staff had been recruited to roles in all areas of the practice, and staffing levels were more stable, but recruitment was ongoing for a number of clinical and non-clinical posts. There were some difficulties with retaining staff, the practice undertook exit interviews with staff to review any themes and learning. • ¹ There were systems in place to regularly review staffing levels by the practice management team and partners. In addition, systems were in place to increase capacity during identified periods of increased demand, for example following public holidays. • ² Induction packs for temporary staff, including locums were now in place. We reviewed two files and saw they contained relevant induction information, for example immunisation status, safeguarding compliance, references, verification of cervical screening training competencies and code of conduct. • ^{3&4} Training records showed all staff had completed sepsis awareness training or were in the process of undertaking training as part of the induction process. Staff we spoke with were able to describe emergency procedures and the location of emergency equipment. | |

- ⁵The provider had undertaken a successful recruitment campaign, however staffing levels remained below local and national averages in clinical workforce levels. The practice conducted risk assessments and staffing levels were reviewed at weekly management meetings.

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. ¹ | Yes |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Yes |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | Yes |
| Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals. | Yes ¹ |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Yes ² |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | Yes |
| Explanation of any answers and additional evidence: | |
| At our last inspection in May 2022 we found: | |
| <ul style="list-style-type: none"> • ¹ There was no evidence that systems were effective in prioritising referrals or reducing delays. • ² The practice was not able to provide evidence that routine tasks were actioned in line with the practice policy. | |
| During our inspection in January 2023 we found: | |
| <ul style="list-style-type: none"> • ¹Review of patient records in relation to the clinical searches identified that care records were managed in line with current guidance. The practice had introduced a clinical information scanning and workflow policy in September 2022 to support effective correspondence management. • ¹On the day of the inspection staff informed us there were 30 routine referrals on the patient record system waiting to be processed. Patients were advised to seek further advice if they had concerns regarding the management of their condition whilst awaiting referral to secondary care. • ² The practice had implemented a GP buddy system to ensure pathology results were reviewed in the absence of the named GP. The secretarial team used a rating system to prioritise workflow. There were no delays in actioning results that required prompt action. • A GP partner had been identified as the scanning lead and provided support to team leaders, including regular correspondence management audits. • The practice had a system in place for the management of referrals under the two-week wait process (for suspected cancer diagnosis) supported by a safety netting process. | |

Appropriate and safe use of medicines

The practice had 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 average | England comparison |
|--|----------|---------------|-----------------|--------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHS Business Service Authority - NHSBSA) | 1.00 | 1.00 | 0.82 | 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). (01/10/2021 to 30/09/2022) (NHSBSA) | 9.3% | 9.0% | 8.5% | 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 (01/04/2022 to 30/09/2022) (NHSBSA) | 5.33 | 5.57 | 5.28 | No statistical variation |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA) | 74.9‰ | 87.1‰ | 128.0‰ | No statistical variation |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA) | 0.46 | 0.44 | 0.58 | No statistical variation |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA) | 6.2‰ | 6.5‰ | 6.7‰ | No statistical variation |

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

| Medicines management | Y/N/Partial |
|--|------------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Yes ¹ |
| Blank prescriptions were kept securely, and their use monitored in line with national guidance. | Yes |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Yes |
| 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. | Yes ² |
| There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. ¹ | Yes ³ |
| 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. | Yes |
| 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. ² | Yes ⁴ |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Yes |
| There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer. | Yes |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | N/A |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Yes |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Yes |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Yes ⁵ |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Yes |
| Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective. | Yes |
| Explanation of any answers and additional evidence, including from clinical searches. | |
| At our last inspection in May 2022 we found: | |
| <ul style="list-style-type: none"> ¹Medicines were stored in a room with a broken key coded door and a security risk assessment had not been completed. ²There was not a system in place to demonstrate the prescribing competence of non-medical prescribers. | |

| Medicines management | Y/N/Partial |
|--|-------------|
| <ul style="list-style-type: none"> • ³Not all patients prescribed repeat medicines had received a structured medicines review in the last 12 months. • ⁴We identified the system for managing patients prescribed high risk medicines was not effective. • ⁵Not all recommended emergency medicines were held on site. | |
| <p>During our inspection in January 2023 we found:</p> | |
| <ul style="list-style-type: none"> • ¹Medicines were stored safely and securely. We observed one fridge used to store medicines was not being used due to an identified fault. A risk assessment had been completed and actions had been identified. • ²The practice had developed a learning framework for GP trainees and advanced care practitioners in July 2022. We saw systems in place to support and review clinical practice to ensure clinical management was in line with national guidance. Identified staff had access to mentorship through an educational supervisor within the practice; staff we spoke with said they felt supported by this process. • Since our previous inspection, the practice had developed their own sustainable medicines management plan to ensure safe prescribing and drug monitoring. The system had been designed to prevent prescribing errors and identify medicines monitoring requirements, alert staff the unsafe prescribing and monitor prescribing. This was a recent initiative and would take some time to become fully embedded, but we observed that this was a notable development which in the longer-term could be shared with others as best practice. • ³ Patients prescribed medicines on a repeating prescription had received structured medicines review. The practice sent regular reminder text messages to patients inviting them for review. Not all patients responded to these messages, and there was evidence that supportive follow up from clinical staff was in place to encourage patients to undertake any required tests are part of the monitoring process. Prescribing clerks and care coordinators provided a supportive role contacting patients on an individual basis. Structured Medication Reviews (SMR's) had been identified as a learning event at a clinical governance meeting in August 2022. Staff we spoke with told us that they felt more comfortable having these medicines processes in place. There were systems in place to implement new searches onto clinical systems when required to support safe medicines management. The practice had identified this as an area for review and further monitoring. • ⁴We reviewed the monitoring of patients prescribed high risk medicines and found these to be in line with recommended monitoring requirements. <ul style="list-style-type: none"> ➤ We reviewed 4 patients prescribed disease modifying anti-rheumatic drugs (DMARD) who had not had the required monitoring in the last 6 months. Two patients were being monitored by secondary care. One patient had been issued a reminder that their monitoring was due, and a supportive conversation arranged with clinical staff. There were no concerns noted for the other patient identified. Following the inspection, we saw the practice had taken appropriate action again to recall the patient for monitoring. • The practice had introduced a drug monitoring protocol in September 2022. In addition, the practice had introduced a monthly audit system for focused, risk stratified action. For example, drug monitoring action was adjusted to patient population groups, including end of life, housebound and frailty patients. The practice had developed alerts within clinical systems to support drug monitoring and action. • ⁵ The emergency equipment trolley had been relocated and emergency bag updated and contained packs to easily identify differing emergency scenarios, for example anaphylaxis and cardiac events. Staff we spoke with were able to describe how to access the equipment in an | |

| Medicines management | Y/N/Partial |
|---|-------------|
| emergency. Minor surgery was undertaken onsite and we saw that Atropine, a medicine used to treat the symptoms of low heart rate (bradycardia), a complication of minor surgery, was available. | |

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. | Yes |
| Staff knew how to identify and report concerns, safety incidents and near misses. | Yes |
| There was a system for recording and acting on significant events. | Yes |
| Staff understood how to raise concerns and report incidents both internally and externally. | Yes |
| There was evidence of learning and dissemination of information. | Yes |
| Number of events recorded in last 12 months: | 27 |
| Number of events that required action: | 27 |
| Explanation of any answers and additional evidence: | |
| <p>At our last inspection in May 2022 we found:</p> <ul style="list-style-type: none"> We did not see evidence that significant events were discussed routinely at team meetings. During the inspection, we identified incidents that had not been reported. <p>During our inspection in January 2023 we found:</p> <ul style="list-style-type: none"> The practice had a procedure for recording significant events and sharing information and learning outcomes as a team. A central spreadsheet had been developed to monitor actions. Staff told us there had been some delay in ensuring actions had been followed up, but there was a plan in place going forward to address this. Significant events were discussed at clinical governance meetings and were a standing agenda item. The practice had implemented a system to ensure staff had access to meeting minutes. There was an open culture to raise safety concerns and staff we spoke with felt supported in the process. | |

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

| Event | Specific action taken |
|--|---|
| Incorrect patient referral pathway actioned. | Referral returned to the practice. Patient informed and referred to correct pathway. Further training provided to staff member. Incident and learning shared on the practice central learning system. |

| | |
|--|---|
| Consultation undertaken with the wrong patient and recorded in the incorrect patient record. | Incorrect patient responded to the name called in reception area. Patient confirmed the incorrect name during the consultation and consultation undertaken. Apology given to both patients; medicines re-prescribed. At the time of the incident the electronic notice board was faulty. Staff reminded to confirm patient details verbally before commencing each consultation. Incident and learning shared on central learning system. |
|--|---|

| Safety alerts | | Y/N/Partial |
|--|--|-------------|
| There was a system for recording and acting on safety alerts. | | Yes |
| Staff understood how to deal with alerts. | | Yes |
| Explanation of any answers and additional evidence: | | |
| At our last inspection in May 2022 we found: | | |
| <ul style="list-style-type: none"> Patients prescribed medicines against the guidance from safety alerts. Patients with asthma prescribed two or more prescriptions of rescue steroids had not been issued with an emergency steroid card in line with a 2020 NHS England and NHS Improvement National Patient Safety Alert (NPSA)- Steroid Emergency Care to support early recognition and treatment of medical emergencies. | | |
| During our inspection in January 2023: | | |
| <ul style="list-style-type: none"> We saw examples of actions taken on recent safety alerts, for example, for medicines which may cause birth defects if they are used during pregnancy. As part of our remote searches, we reviewed five patients who were prescribed these medicines and were of an age where pregnancy could be possible. We saw that there were no issues with the monitoring of these patients, and all had been informed of the associated risks. As part of our searches we reviewed two patients who were prescribed two different medicines, which when combined, created a potential increased risk of muscle pain/damage. This had been highlighted by a Medicines and Healthcare products Regulatory Agency(MHRA) alert. We were unable to see evidence that the two identified patients had been informed about the risk of this combination. During the inspection the practice had undertaken a review and concluded both patients had been prescribed a branded product of medicines not included in the practice search criteria. Both patients were contacted and changed to a suitable alternative. The practice had implemented a process for managing patient safety alerts, which included a protocol for sharing and acting on alerts, in September 2022. The practice had received support from commissioners to further strengthen this process. All alerts were received centrally and reviewed and disseminated to leads for action. Safety alerts were a standing agenda item at clinical governance meetings. All relevant staff had access to a central system to review the alerts and relevant guidance and there were systems in place to monitor actions. | | |

Effective

Rating: Requires improvement

At the last inspection in May 2022 we rated the practice as inadequate for providing **effective** services because:

- Patients' needs had not been sufficiently assessed and cared for;
- Patients who were vulnerable or had a long term condition had not been proactively monitored throughout the pandemic;
- Childhood immunisations and cervical cancer screening indicators remained below national target uptake rates;
- The practice had failed to use data and information from its clinical record system to drive improvements or monitor care;
- Staff did not always have the training and skills to provide care.

In January 2023, we saw that overall improvements had been made and changes to systems and processes were in place to continue to improve and embedded effective services, however these still required strengthening. We rated the practice as requires improvement for providing **effective** services because:

- Whilst the practice had made improvements to ensure patients ongoing needs were fully assessed and delivered in line with current guidance, we identified, through our clinical searches, that in some areas further monitoring was required.
- Childhood immunisation indicators and cervical cancer screening indicators remained below national uptake rate targets, however the practice had taken measures to increase uptake and support patients with their decision making.
- There were improvements in system and processes to monitor staff training. However, there were still gaps in the practice's mandatory training schedule.

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

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

| | Y/N/Partial |
|--|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | Yes |

| | |
|---|----------------------|
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Yes |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | Yes ¹ |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Yes |
| Patients' treatment was regularly reviewed and updated. | Partial ² |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Yes |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Yes ³ |
| The practice prioritised care for their most clinically vulnerable patients. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in May 2022 we found:</p> <ul style="list-style-type: none"> • ¹A significant number of outstanding tasks and referrals which had not been actioned; • ² Patients' treatment was not always reviewed regularly; • ³ Patients with Asthma were not always followed up in line with guidelines. <p>During our inspection in January 2023 we found:</p> <ul style="list-style-type: none"> • ¹The practice had made improvements in the management, review and actioning on referrals and tasks. The practice offered overtime to staff to help manage workload and recruited staff to reduce the backlog. The practice received a significant number of correspondence daily. Management and leaders had weekly oversight of the number of tasks outstanding and there were systems in place to manage and prioritise workload if a member of the team was absent. • ² As part of our remote searches we reviewed the monitoring of patients with hypothyroidism and found that whilst there had been improvements in the system to monitoring patients not all were in line with recommended monitoring requirements. <ul style="list-style-type: none"> ➤ We found 549 patients with hypothyroidism and identified seven patients who had not had the required monitoring. We reviewed five sets of patient records, we found four patients had been identified by the practice and their medicines had been reduced. Following the inspection, the practice provided assurances that the remaining patient had been recalled. • As part of our remote searches identified 167 patients as having a potential missed Chronic Kidney Disease diagnosis. After the inspection the practice conducted their own review and identified that 95 patients were confirmed as having Chronic Kidney Disease and measures were put in place to contact these patients. A further 57 patients required monitoring of their condition. The practice confirmed an action plan had been put in place to provide necessary monitoring. <p>³ As part of our remote searches we reviewed the monitoring of patients with asthma potentially poorly controlled asthma.</p> <ul style="list-style-type: none"> ➤ We reviewed five sets of patient records, we found that all patients had received an appropriate assessment at the time of prescribing medicines. One patient had not had an annual review undertaken in the last 12 months, in addition one patient had not been issued a steroid card; this is used to improve patient safety for patients with potential adrenal insufficiency. During the inspection the practice provided assurances and described a monthly monitoring system in place for patients requiring steroid cards. | |

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 demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services. Patients were offered double appointment, when required.

Management of people with long term conditions

Findings

- Patients with a diagnosed long term conditions were offered an 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. The practice had identified areas of focus for chronic disease patients, including respiratory patients, and patients prescribed medicines to assist with anxiety and insomnia.
- The practice had developed a range of medicine searches, which included monitoring of patients prescribed medicines to support the management of their long term conditions.
- 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.
- Patients with diabetes were risk stratified to ensure patients at higher risk were prioritised. Patients had access to a diabetes clinical lead and diabetes specialist nurse.

| 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) (UKHSA COVER team) | 199 | 228 | 87.3% | Below 90% minimum |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (UKHSA COVER team) | 207 | 227 | 91.2% | Met 90% minimum |
| The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (UKHSA COVER team) | 206 | 227 | 90.7% | Met 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) (UKHSA COVER team) | 210 | 227 | 92.5% | Met 90% minimum |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (UKHSA COVER team) | 246 | 274 | 89.8% | Below 90% minimum |

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

Any additional evidence or comments

Explanation of any answers and additional evidence:

At our last inspection in May 2022 we found:

- The practice had not achieved the World Health Organisation minimum target for childhood immunisations in two of the five indicators.

During our inspection in January 2023 we found:

- Figures remained the same due to the length of time since the last inspection.
- The practice had taken measures to improve uptake, for example social prescribers proactively contacted patients on a rolling monthly basis to support decision making for patients.
- The practice had recruited a locum nurse to provide additional capacity for appointments in the evening and at weekends and had worked with other agencies to increase capacity.
- Patients were risk stratified to ensure patients at higher risk were prioritised.
- The practice had implemented an online self-booking system for patients.
- The practice undertook monthly audits to monitor the uptake.
- During the inspection we saw information displayed in the practice to promote uptake.

| Cancer Indicators | Practice | SICBL 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: 30/06/2022) (UK Health and Security Agency) | 70.3% | N/A | 80% Target | Below 80% target |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA) | 27.6% | 56.7% | 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) | 61.6% | 66.6% | 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) | 39.4% | 52.1% | 55.4% | No statistical variation |

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.

Any additional evidence or comments

During our inspection in May 2022, we found:

- Cervical screening indicators remained below the national UK Health and Security Agency target of 80% for cervical cancer screening uptake. Staff told us that a plan was in place and action had been taken to increase uptake.

During our inspection in January 2023 we found:

- Improvements in meeting the target, however the practice was still below the Public Health England target of 80%. The practice told us this was an area of focus.
- The practice had employed additional staff to reduce the backlog, identified any high-risk groups and had utilised care co-ordinators to contact these patients.
- The practice held additional clinics to reduce the backlog, for example the practice had carried out 119 screening appointments in October 2022.
- A quality improvement project had been commenced within the practice and this project had identified a number of improvements to the call and recall process.
- Weekly reviews between the lead partner and care co-ordinators took place to ensure high-risk patients were identified and supported.
- The practice had implemented an online self-booking system.
- The practice had reintroduced a monthly clinical screening tool to assess the number of patients invited and screened.
- During the inspection we saw information regarding cervical cancer screening was displayed within the practice waiting areas.

- The practice had utilised flu clinics as an opportunity to identify and engage with any patients identified as eligible for screening.

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. | Yes |
| The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements. | Yes |
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action. | Yes |

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

- The practice had undertaken a schedule of audits covering a range of internal processes, including medicines management and infection prevention and control.
- The practice had implemented an audit cycle process, and 3 monthly cycles were planned with annual reviews.
- We were provided with examples of recently completed audits.
- The practice had undertaken a two-cycle unopposed oestrogen audit in January 2023. Unopposed oestrogen means a second hormone, progestogen, is not used with the oestrogen. The audit identified patients prescribed unopposed oestrogen with a uterus intact, which can lead to an increased risk to patients. The audit identified 108 patients, and three patients prescribed unopposed oestrogen as directed by a gender identity clinic. The audit confirmed 100% compliance against the standard. This demonstrated an improvement compared to the first audit at 97%. A further re-audit was planned in June 2023.
- The practice had undertaken a two-cycle audit on broad spectrum antibiotic prescribing in December 2022. The audit formed part of a programme of antimicrobial stewardship. A review of antibiotic prescribing in December 2022 identified 22 patients prescribed broad spectrum antibiotics. A further review identified 12 patients prescribed by staff at the practice. Ten other patients had been prescribed by external providers, including out of hours care. A review of the 12 patients identified inappropriate prescribing for one patient. The audit was scheduled to be discussed at a future clinical governance meeting, individual learning had been identified and repeat audit planned.

Any additional evidence or comments

The practice had identified, and were in the process of completing, three quality improvement projects to review access, the management of correspondence information and cervical screening. The practice was supported by commissioners. In addition, the practice had enrolled in the NHS England Accelerate programme which aimed at reviewing access and patient flow, correspondence management and further modules were in the process of being identified.

Effective staffing

Overall, the practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles, however this required strengthening.

| | Y/N/Partial |
|---|----------------------|
| Staff had the skills, knowledge and experience to deliver effective care, support and treatment. | Partial ¹ |
| The practice had a programme of learning and development. | Yes |
| Staff had protected time for learning and development. | Yes |
| There was an induction programme for new staff. | Yes |
| Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation. | Yes |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | Yes |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>During our inspection in May 2022, we found:</p> <ul style="list-style-type: none"> We identified gaps in staff training. For example five members of staff had not completed fire safety training within the last 12 months, two clinical staff members who did not have a record of safeguarding training completed at either Level 1, 2 or 3 for both adults and children and one clinical staff member had only completed Level 1. Nine members of staff did not have evidence of completed Infection Prevention and Control training and 11 clinical members of staff adult basic life support training had expired. <p>During our inspection in January 2023 we found:</p> <ul style="list-style-type: none"> ¹There were improvements in system and processes to monitor staff training. However, there were still gaps in the practice's mandatory training schedule. This was closely monitored by the practice management team and Partners. One clinical member of staff, and one non clinical member of staff were not up to date with fire safety training. One member of staff had been unable to complete this due to unexpected leave. All staff had completed Infection Prevention and Control training. All members of staff had completed adult basic life support training, or a plan was in place for new members of staff to complete the training as part of their induction programme. Staff who administered vaccines had received anaphylaxis training as part of the basic life support training. Display Screen Equipment, General Data Protection Regulation (GDPR) and Moving and Handling training compliance had improved. In order to address the backlog of training identified at the last inspection, staff told us they were offered overtime to complete training in their own time, if required. | |

- There were systems in place to monitor and complete staff appraisal and personal development plans. We observed a sample of these and found these were good quality with personal objectives. Staff on extended leave had been offered keep in touch days to support learning and development. Staff we spoke with told us they felt supported and described a range of external development opportunities being undertaken.
- There was an induction programme in place for staff, aligned to their individual roles.
- We saw examples of how new and existing staff competencies were assessed. All staff we spoke to described being supported by managers and colleagues when they started their roles. Staff were able to access formal and informal supervision.

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. | Yes |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Clinical meetings were held on a weekly basis. The practice hosted palliative care multidisciplinary meetings on a monthly basis to review the management of patients on an end of life care pathway. Prescribing meetings were scheduled on a monthly basis, however staff told us that the meetings had not occurred for several months due to staff availability and workload demands. Clinical governance meetings were held regularly for all staff. • The practice team held weekly multidisciplinary meeting with the local care home. Care home staff were able to contact the practice directly for urgent consultations. • The practice was in the process of working towards dementia friendly accreditation. | |

Helping patients to live healthier lives

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

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

Any additional evidence or comments

- At the time of the inspection patients had access to lung screening and scanning facilities hosted on behalf of the Primary Care Network (PCN) within the practice grounds.
- Patients had access to a health and wellbeing coach. Patients were able to self-refer to this service. Patients were signposted to additional services, for example walking groups and weight management programmes.

Consent to care and treatment

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

| | Y/N/Partial |
|--|-------------|
| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | Yes |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | Yes |
| Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹ | Yes |
| Explanation of any answers and additional evidence, including from clinical searches: <ul style="list-style-type: none">We reviewed a random sample of DNACPR records and were assured that these were made in line with relevant legislation, for example signed by an appropriate clinician. | |

Caring

Rating: Requires improvement

At the last inspection in May 2022 we rated the practice as good for providing **caring** services because:

- National GP patient survey results relating to patient experience were in line, or just below local and national averages.

At this inspection in January 2023, we rated the practice as requires improvement for providing **caring** services because:

- The results from the national patient survey demonstrated a decline in patient satisfaction in all four indicators. The practice were aware of these results, an action plan was in place. The practice was being supported by both local commissioners and NHS England to identify improvements for patients.

Kindness, respect and compassion

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

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

| Patient feedback | |
|--------------------|---|
| Source | Feedback |
| Patient interviews | Patients we spoke with during the inspection told us that staff were kind and treated them with respect. We observed reception staff treating patients with compassion. |
| NHS website | We reviewed all the reviews in the previous 12 months (7 comments). All seven reviews left 1-star ratings. Themes included difficulties in accessing services, including appointments, text messaging and communication concerns. There were positive comments related to staff, for example reception staff. The practice had responded to two comments. |
| Practice survey | The practice undertook practice surveys. At the time of the inspection the practice had not analysed the survey results to identify any themes, trends or areas of improvement. |
| CQC enquiries | In the last 12 months, nine of the 46 enquiries received by CQC included information about the practice providing caring services. Positive comments included staff described as polite and sympathetic. Negative comments were in relation to staff attitude and staff support at the point of access. |

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 average | England comparison |
|---|----------|---------------|-----------------|----------------------|
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022) | 69.3% | 82.6% | 84.7% | Variation (negative) |
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022) | 67.1% | 80.8% | 83.5% | Variation (negative) |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022) | 79.8% | 91.5% | 93.1% | Variation (negative) |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022) | 46.0% | 66.6% | 72.4% | Variation (negative) |

Any additional evidence or comments

We reviewed the most recent published National GP Patient Survey 2022 results for the practice. The percentage of respondents to the GP patient survey who stated at the last time they had a general practice appointment; the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022) was 69.3%. This was below the local average of 82.6% and national average of 84.7% and a reduction from 80.4% in 2021.

The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice was 46.0%. This was below the local average of 66.6% and national average of 72.4%. This was a reduction from 68.2% in 2021.

The practice was aware of the results and since the last inspection the practice had:

- Enrolled in local commissioner and NHE England and NHS Improvement accelerate quality improvement programme.
- Undertaken a recruitment programme and was now fully staffed in reception.
- Increased the opening time of the reception area until from 6.00pm to 6.30pm
- Staff told us there had been a reduction in informal complaints raised regarding access to reception

- Telephony options had been reviewed and the practice had implemented a call back function for patients.
- Posters detailing interpreting services were now displayed in the waiting areas.
- The number of face to face appointments had been increased.

| Question | Y/N |
|---|-----|
| The practice carries out its own patient survey/patient feedback exercises. | Yes |

Any additional evidence

During our inspection in May 2022 we found the practice had developed their own patient survey and the questions were aligned to those in the national survey to enable the practice to compare results. The practice had collated the feedback but had not yet had an opportunity to analyse and identify areas for action and improvement.

During our inspection in January 2023 we found the practice had continued to carry out its own patient survey. The practice shared 28 feedback forms, the majority were negative in line with national and local data. We saw that the practice had acted upon feedback, for example the telephone system was in the process of being upgraded and improved as patients had commented on this.

Involvement in decisions about care and treatment

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

| | Y/N/Partial |
|---|-------------|
| Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given. | Yes |
| Staff helped patients and their carers find further information and access community and advocacy services. | Yes |

| Source | Feedback |
|-------------------------|--|
| Feedback from patients. | Feedback we recovered from patients included complaints regarding access and choice of appointments. |

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 average | England comparison |
|--|----------|---------------|-----------------|--------------------------------------|
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022) | 81.4% | 89.3% | 89.9% | Tending towards variation (negative) |

Any additional evidence or comments

The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022) was 81.4%. This was below the local average of 89.3% and national average of 89.9% and a reduction from 89.7% in 2021.

| | Y/N/Partial |
|--|-------------|
| Interpretation services were available for patients who did not have English as a first language. | Yes |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | Yes |
| Information leaflets were available in other languages and in easy read format. | Yes |
| Information about support groups was available on the practice website. | Yes |
| Explanation of any answers and additional evidence: During the inspection staff confirmed an audio induction loop (hearing loop) was available to patients. | |

| Carers | Narrative |
|---|--|
| Percentage and number of carers identified. | The practice had identified 293 patients and carers, this represented 1.4% of the practice population. |
| How the practice supported carers (including young carers). | The practice held a register of carers. The practice directed carers to local support services. Carers were identified on the practice clinical system and patients were able to access support information on the practice website. A carer's guide was available for patients. |
| How the practice supported recently bereaved patients. | Staff contacted patients if they became aware of bereavements and directed patients to local support services. |

Privacy and dignity

The practice respected patients' privacy and dignity.

| | Y/N/Partial |
|--|-------------|
| A private room was available if patients were distressed or wanted to discuss sensitive issues. | Yes |
| There were arrangements to ensure confidentiality at the reception desk. | Yes |
| Explanation of any answers and additional evidence: A chaperone policy was in place and posters advertising the availability of chaperones was available in clinical rooms. | |

Responsive

Rating: Requires Improvement

At the last inspection in May 2022, we rated the provider as inadequate for providing **responsive** services because:

- The National GP Patient Survey 2021 results for the practice were lower than local and national averages in three of the four indicators in respect to providing responsive services. This was a trend over time.
- The practice had not always been responsive to the needs of their patients.
- Complaints were not always managed effectively. Opportunities to learn from complaints and to improve the quality of care had been missed.

Following our inspection in January 2023, the practice is now rated as **requires improvement** in the responsive key question because:

- The National GP Patient Survey 2021 results for the practice were lower than local and national averages in all four indicators in respect to providing responsive services. This was a trend over time. However, the practice had taken action to address these results, for example patients had increased access to the practice. In addition, the practice had enrolled in the NHS England Access Improvement Programme to identify methods for improving access for patients and had been working with commissioners to identify additional options for improving access.
- The practice had reviewed and made adjustments in response to the needs of their patients. For example, the practice had increased the number of receptionists recruited to answer telephone calls and increased the number of face to face appointments.
- Opportunities to learn from complaints and improve the quality of care required further development and embedding.

Responding to and meeting people's needs

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

| | Y/N/Partial |
|--|-------------|
| The practice understood the needs of its local population and had developed services in response to those needs. | Yes |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided. | Yes |
| The facilities and premises were appropriate for the services being delivered. | Yes |
| The practice made reasonable adjustments when patients found it hard to access services. | Yes |
| There were arrangements in place for people who need translation services. | Yes |
| The practice complied with the Accessible Information Standard. | Yes |
| Explanation of any answers and additional evidence: | |

Since the last inspection the practice had:

- Extended the closing time of the reception areas from 6pm to 6:30pm
- The practice had invested in additional telephony options for patients to address issues with waiting times.
- The practice had increased the number of face to face appointments available and all urgent appointments were delivered face to face.
- Introduced an online booking service for identified services, for example cervical screening and flu clinics.
- Patients continued to have access to extended access appointments, this included a dedicated number for all extended access queries Monday to Friday 9am to 5pm. Patients had access to additional pre-booked appointments and weekend GP services operating from six locations, the service was provided by the local out of hours service provider.
- Members of the public had access to a large car park with designated disabled bays.
- A pharmacy and a dental clinic were located within the same building.

Practice Opening Times

| Day | Time |
|-------------------------|---|
| Opening times: | |
| Monday | 8am – 6.30pm |
| Tuesday | 8am – 6.30pm |
| Wednesday | 8am – 6.30pm |
| Thursday | 8am – 6.30pm |
| Friday | 8am – 6.30pm |
| Appointments available: | |
| Monday | 8.10am – 11.50am 1.30pm -5.50pm |
| Tuesday | 8.10am – 11.50am 1.30pm -5.50pm |
| Wednesday | 8.10am – 11.50am 1.30pm -5.50pm |
| Thursday | 8.10am – 11.50am 1.30pm -5.50pm |
| Friday | 8.10am – 11.50am 1.30pm -5.50pm |
| | Duty doctor appointments available until 6.30pm |

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Patients were offered extended access appointments on Saturdays.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people and refugees.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- The practice provided a service to patients registered at a local care home and visited as and when required.

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 minimize the length of time people waited for care, treatment or advice | Partial ¹ |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online) | Yes ² |
| Patients were able to make appointments in a way which met their needs | Partial ³ |
| There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded). | Yes |
| Patients with most urgent needs had their care and treatment prioritised | Yes |
| There was information available for patients to support them to understand how to access services (including on websites and telephone messages) | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in May 2022 we found:</p> <p>¹CQC had received feedback from patients in relation to poor access to appointments. The practice told us they were working with the local commissioners to consider ways to improve patient feedback.</p> <p>² The practice had been identified as a low provider of face to face appointment by commissioners.</p> <p>During our inspection in January 2023 we found:</p> <p>¹ We had continued to receive feedback from patients in relation to poor access and staff told us patients continued to report issues with access to the practice using the telephone system. The practice had enrolled in the NHS England Access Improvement Programme to identify methods for improving access for patients and had been working with commissioners to identify additional options for improving access. For example, the practice had introduced an online booking system to support patient access and the telephone system had been updated to include a call back function for patients. The practice had increased the number of face to face appointments and an action plan was in place to monitor access support.</p> <p>² The practice confirmed they were providing more face to face appointments and all urgent appointments were delivered face to face.</p> <p>³ Patients joined a queue system to access appointments on site at 8.00am and at 11.30am. On the day of inspection, we saw queues of patients waiting to access the reception desk. We saw that reception staff were signposting and informing patients of waiting times, other methods of appointment booking and the likelihood of an appointment being available on the day.</p> | |

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 average | England comparison |
|---|----------|---------------|-----------------|----------------------------------|
| The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022) | 16.7% | 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) | 23.7% | 50.9% | 56.2% | Variation (negative) |
| 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) | 25.1% | 48.0% | 55.2% | 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) | 42.0% | 66.0% | 71.9% | Significant Variation (negative) |

Any additional evidence or comments

We reviewed the most recent published National GP Survey 2022 results for the practice. The results identified the percentage of respondents who responded positively to how easy it was to get through to someone at their GP practice on the phone - 16.7% compared to the England average of 52.7%. This was a negative trend over time and a reduction from 17.6% in 2021.

National GP patient survey results identified the percentage of respondents who responded positively to the overall experience of making an appointment 23.7% compared to the England average of 56.2%. This was a negative trend over time and a reduction from 41.4% in 2021.

National GP patient survey results identified the percentage of respondents who were satisfied with the appointment (or appointments) they were offered 42.0 % compared to the England average of 71.9%. This was a negative trend over time and a reduction from 81.7% in 2021.

On the day of inspection, we saw improvements in the access to the telephony system. The longest time a member of the public had waited to get through to the practice was 25 minutes with an average call answer time of 10 minutes. There were 22 patients in the call queue. Staff told us that by approximately 08.30 all appointments had been allocated for the morning. Reception staff confirmed there were mitigations plans in place to increase capacity for emergency appointments, if required. Staff had access to a call monitoring system and reviewed the activity daily.

The practice had enrolled in the NHS England Access Improvement Programme to identify methods for improving access for patients and had been working with commissioners to identify additional options for improving access.

| Source | Feedback |
|-----------------------------------|--|
| NHS website | We reviewed all the reviews on the NHS website (seven reviews left from January 2022 to January 2023). All seven reviews left 1-star rating. Themes included difficulties in accessing services, including appointments and text messages/communication concerns. There were positive comments related to staff, for example reception staff. The practice had responded to two of the comments. |
| CQC enquiries | In the last 12 months, 21 of the 46 enquiries received by CQC related to access and people's experience of requesting and obtaining an appointment and access through the practices phone system. |
| Patient Participation Group (PPG) | PPG representatives shared their personal experiences of accessing appointments, and of other patients they had spoken to. They told us there were still concerns regarding access, in particular with access to routine appointments, however they had experienced some improvements in the way in which patients had been signposted to services within the practice. |

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care. However, this required further strengthening.

| Complaints | |
|--|-----|
| Number of complaints received in the last year. | 116 |
| Number of complaints we examined. | 3 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 3 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | 1 |

| | Y/N/Partial |
|--|----------------------|
| Information about how to complain was readily available. | Yes |
| There was evidence that complaints were used to drive continuous improvement. | ¹ Partial |
| Explanation of any answers and additional evidence: | |
| <p>¹The management team were responsible for the management of complaints. Since the last inspection complaints management had been included as a standard agenda item at clinical governance meeting agendas, however complaints were not always presented at these meetings. The practice had introduced learning events and all staff had access to read the content of the meetings on a shared system to learn from individual complaints. The practice had future plans to identify and review themes of complaints and were in the process of implementing a complaints toolkit to support this work.</p> <p>On the day of the inspection we reviewed three complaints and found that they had been handled in a timely way, however when we reviewed the complaints management system we identified that not all complaints had been responded to in line with the practice policy timeframes. The practice had</p> | |

reviewed the complaints process and had identified a lack of resources had affected efficiencies. The practice shared their plan for improvement, for example complaints to be a standard agenda item at partner and staff meetings and to embed escalation processes within the practice to support local resolution.

Information about how to make a complaint, suggestion or compliment was available accessible on the practice website.

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|---|---|
| Complaint received about a face to face appointment to discuss test results. | Complaint reviewed by Practice Manager, complaints discussed with Clinical Pharmacist and action plan agreed with patient. |
| Complaint received about a long waiting time on telephone system to access appointment. | Appointment offered to patient later the same day. Telephone system updated to include option for patient call back. |
| Complaint received about text messaging system to patients. | Complaint investigated; text messaging system restricted to a limited number of characters. Text messages reviewed and amended. |

Well-led

Rating: Requires Improvement

At our previous inspection in May 2022, we rated the practice as inadequate for providing **well-led** services. This was because:

- The leadership team were unable to demonstrate they had implemented effective governance systems and process to ensure the delivery of safe and effective care.

Following the inspection in January 2023, the practice is now rated as requires improvement in the **well-led** key question because:

- Leaders had been proactive in their response to the outcome of our previous inspection.
- The provider had commissioned additional managerial staff to provide advice and guidance to the practice management team.
- Leaders had worked collaboratively with commissioners and external partners to implement more effective governance processes.
- Each partner had an identified team lead role.
- The provider had undertaken a successful recruitment campaign to support, and increase, the delivery of activity to meet improve capacity to patient demand.

However:

- Complaints were not always acted on in a timely way and opportunities to learn from complaints and improve the quality of care required further development and embedding.
- Whilst the practice had made improvements to ensure patients ongoing needs were fully assessed and delivered in line with current guidance, this required further development.

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. | Yes |
| They had identified the actions necessary to address these challenges. | Yes |
| Staff reported that leaders were visible and approachable. | Yes |
| There was a leadership development programme, including a succession plan. | ¹ Partial |
| Explanation of any answers and additional evidence: | |
| At the last inspection in May 2023 we found: <ul style="list-style-type: none">• Limited evidence of ownership of risk, risk action plans and service improvements.• There was not an effective system in place manage actions in a timely manner.• Staff told us leaders were not always visible and approachable.• There were no plans in place to consider succession planning. | |
| During the inspection in January 2023 we found: | |

- Leaders had been proactive in their response to the outcome of our previous inspection. Partners and managers had worked extensively with commissioners to try and address the concerns that were identified.
- After the inspection in May 2022, the partners had commissioned an experienced practice management consultant to provide advice and guidance to the practice. In addition, the partners had commissioned additional short-term support from two further practice managers. We saw that this had added additional expertise to drive improvement and increased capacity to support the existing practice management team and partners through this difficult period.
- Since the previous inspection the practice had sought assistance from NHS England accelerate programme to review and improve access and recruitment and retention of staff.
- Partners and managers had continued to meet weekly. We saw a rating system in place to monitor outstanding tasks and actions and staffing levels.
- The practice continued to work with other local practices as part of the Harlow South Primary Care Network. The practice was the lead practice for the PCN, in addition one partner undertook the role of Primary Care Network Clinical Director. We saw examples of innovation through the PCN, for example at the time of the inspection the practice site had been made available to host a mobile lung surveillance service.
- The practice had identified designated partner roles and staff had access to leads for support. Staff told us that they had found this approach helpful and supportive. Clinical governance minutes we reviewed showed that identified leads had presented topics for learning to staff meeting, for example the safeguarding lead had provided an update for all staff on safeguarding responsibilities.
- As part of future planning and sustainability, an away day had taken place, supported by the Local Medical Council.

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. | Yes |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Yes |
| Progress against delivery of the strategy was monitored. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Since the last inspection leaders had revised the practice mission statement and core values. The mission statement said, 'The practice mission is to improve the health of those we serve'. • The practice had developed a set of values and had a vision which was available on the practice website. • Feedback from staff questionnaires indicated that staff knew and understood the vision, values and strategy. | |

Culture

The practice had a culture which drove high quality sustainable care, however this required strengthening.

| | Y/N/Partial |
|--|----------------------|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | Yes |
| Staff reported that they felt able to raise concerns without fear of retribution. | Yes |
| There was a strong emphasis on the safety and well-being of staff. | Yes |
| There were systems to ensure compliance with the requirements of the duty of candour. | Yes |
| When people were affected by things that went wrong, they were given an apology and informed of any resulting action. | Partial ¹ |
| The practice encouraged candour, openness and honesty. | Yes |
| The practice had access to a Freedom to Speak Up Guardian. | Yes |
| Staff had undertaken equality and diversity training. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Feedback from staff questionnaires indicated that staff felt able to raise ideas to support the delivery of the strategy at team meetings. Team leads had been identified to give staff an opportunity to meet with the partnership regularly and feedback departmental challenges, good practice and innovation. Staff we spoke with felt able to raise concerns and described examples of this. ¹Complaints were not always acted on in a timely way and opportunities to learn from complaints and improve the quality of care required further development and embedding. There was a system in place to monitor and support staff training on a monthly basis. Staff had access to debrief opportunities. Staff had access to a whistleblowing policy which included details of a Freedom to Speak Up Guardian external to the practice. Staff we spoke with knew how to access support. | |

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

| Source | Feedback |
|-----------------------------------|--|
| Staff feedback and questionnaires | <p>We received 13 staff questionnaires from staff before the inspection. We also held interviews with a range of staff members and talked to members of the practice team on the day of the inspection. Themes from the feedback included:</p> <ul style="list-style-type: none"> The majority of responses indicated that staff had completed training, had received an appraisal and staff knew how to report incidents and risk. Clinical governance meetings had supported learning. In addition, staff found it helpful to have access to a central system for learning. Increased recruitment had supported staff in their roles and reduced the need to work additional hours. We found that staff reported systems and processes had improved and staff were positive about the future. Staff were proud of the work they did. Some staff had enrolled and undertaken additional training to support individual development. |

| | |
|--|---|
| | <ul style="list-style-type: none"> Staff shared areas improvement, for example providing further personalised care for patients, continued development of additional supportive roles in the practice and an increase in staffing levels to support the demand for appointments. |
|--|---|

Governance arrangements

There were clear 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. | Yes |
| Staff were clear about their roles and responsibilities. | Yes |
| There were appropriate governance arrangements with third parties. | Yes |
| There are recovery plans in place to manage backlogs of activity and delays to treatment. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> An updated governance framework for learners and induction programme for GP trainees was in place. Staff we spoke with were clear about their roles and responsibilities. Each partner had a designated team lead role, for example since the last inspection the practice had identified a scanning lead to support the management of clinical information. Since the previous inspection the practice had increased the use of a software package which enabled evidence of learning and dissemination of information. We observed this was working well and there were plans to further develop this in the future. There was a programme of regular meetings held at the practice which covered all aspects of staffing and governance. Meeting were available to the team on the practice software package. The practice had in place an infection prevention control clinical lead, supported by a nurse lead. The practice had a range of policies and procedures which were reviewed and updated as appropriate. Staff knew how to access these. Staff vacancies and recruitment levels were regularly reviewed, and since the last inspection two practice nurses and two health care assistance had been employed, in addition the reception team were now fully staffed. The practice had a recruitment plan in place for additional roles. | |

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

| | Y/N/Partial |
|---|-------------|
| There were comprehensive assurance systems which were regularly reviewed and improved. | Yes |
| There were processes to manage performance. | Yes |
| There was a quality improvement programme in place. | Yes |
| There were effective arrangements for identifying, managing and mitigating risks. | Yes |
| A major incident plan was in place. | Yes |
| Staff were trained in preparation for major incidents. | Yes |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There were systems to identify and control risk. On the day of the inspection lighting had failed on the first-floor corridor, staff shared with us the management and actions taken to mitigate the risk. Staff we spoke with gave examples of risk they had identified and reported to the management team. • The practice had enrolled in a programme of quality improvement with local commissioners and NHS England. There was a written process for audits and audit cycles in place. • There were system in place to regularly review the practice risk register. • The practice considered the impact of service developments or changes. For example, we saw the impact on energy costs due to increased use of the building by external contractors out of hours had been discussed. | |

Appropriate and accurate information

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

| | Y/N/Partial |
|--|-------------|
| Staff used data to monitor and improve performance. | Yes |
| Performance information was used to hold staff and management to account. | Yes |
| Staff whose responsibilities included making statutory notifications understood what this entailed. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We saw that the practice used data provided to review service delivery, for example benchmarking data provided by commissioners to review performance on a range of parameters against local practices and the wider area. | |

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. | Yes |
| The provider was registered as a data controller with the Information Commissioner's Office. | Yes |
| Patient records were held in line with guidance and requirements. | Yes |
| Patients were informed and consent obtained if interactions were recorded. | Yes |
| The practice ensured patients were informed how their records were stored and managed. | Yes |
| Patients were made aware of the information sharing protocol before online services were delivered. | Yes |
| The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services. | Yes |
| Online consultations took place in appropriate environments to ensure confidentiality. | Yes |
| The practice advised patients on how to protect their online information. | Yes |
| Staff are supported to work remotely where applicable. | Yes |

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. | Partial ¹ |
| The practice had an active Patient Participation Group. | Yes ² |
| Staff views were reflected in the planning and delivery of services. | Yes ³ |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in May 2022 we found:</p> <ul style="list-style-type: none"> ¹ There was an ineffective system to demonstrate service wide learning from complaints and significant events. ² The practice did not have an active Patient Participation Group (PPG). ³ Not all staff told us they had been involved in planning and delivery of services. <p>During the inspection in January 2023 we found:</p> | |

- ¹ Complaints management had been included as a standard agenda item at clinical governance meeting agendas, however complaints were not always presented at these meetings. The practice had reviewed the complaints process and had identified a lack of resources had affected efficiencies. The practice shared their plan for improvement, for example complaints to be a standard agenda item at partner and staff meetings.
- ¹The practice had a procedure for recording significant events and sharing information and learning outcomes as a team. Significant events were discussed at clinical governance meetings and were a standing item agenda. The practice had increased the use of a software package which enabled them to collate evidence of learning and dissemination of information
- ¹Regular staff meeting were held, staff had access to protected learning sessions as required.
- ² Patient Participation Group (PPG) meetings had been reinstated. Information regarding the PPG was available on the practice website and waiting areas. The practice had continued to actively recruit new members, patients who had contacted the practice with a complaint were invited to join the group.
- ³ Staff meetings were held, staff views had been considered and actioned, for example to streamline referral processes. Staff had been encouraged to present share and discuss learning topics at these meetings.

Feedback from Patient Participation Group.

Feedback

- We spoke with the PPG chair who reported groups meetings with the Friends of Lister' had been reinstated.
- The PPG had been actively trying to increase the membership of the group.
- Concerns regarding access were still being raised, for example telephone access and waiting times and availability of routine appointments. The group had seen an improvement in the care navigation of patients by the reception team.
- There was positive feedback regarding services to meet the need of specific patient populations, for example access to diabetes specialist service, and respiratory care.
- One member of the PPG had designed and produced a poster for the group which was displayed within the practice.

Continuous improvement and innovation

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

| | Y/N/Partial |
|---|-------------|
| There was a strong focus on continuous learning and improvement. | Yes |
| Learning was shared effectively and used to make improvements. | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • There was a strong commitment to learn and improve. Work had been undertaken by the practice to develop their own medicine management templates to improve patient safety and assist in the delivery of improved patient outcomes. This required further work to be embedded. • Audit was used to review compliance against standards and best practice, and learning was shared at team meetings. | |

- Staff had access to a shared software package which held reflective learning examples for staff.

Examples of continuous learning and improvement

- There was an open-door policy in place for GP trainees, and trainees had access to daily debrief sessions with the duty doctor.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a SICBL 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 SICBL 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.