

Care Quality Commission

Inspection Evidence Table

The Thorndike Surgery (1-545296605)

Inspection date: 21 July 2022

Date of data download: 19 July 2022

Overall rating: Requires Improvement

We rated the practice as Requires Improvement overall because:

- The practice's systems and processes did not always keep people safe and safeguarded from abuse.
- The practice's systems for the appropriate and safe use of medicines, including medicines optimisation, required improvement.
- Improvements were needed to the practice's system for recording and acting on safety alerts.
- Patients' needs were assessed, but care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- Improvements in performance related to childhood immunisations and cervical screening were required.
- Some feedback from patients was negative about the way staff treated people.
- There had been a deterioration in the National GP survey results regarding patient experience.
- The latest National GP Patient Survey results showed that the practice was performing significantly lower than local and national averages for several indicators regarding access to the practice.
- Processes for managing risks, issues and performance required improvement.

Safe

Rating: Requires Improvement

We rated the practice as Requires Improvement for providing safe services because:

- The practice's systems and processes did not always keep people safe and safeguarded from abuse.
- The practice's systems for the appropriate and safe use of medicines, including medicines optimisation, required improvement.
- Improvements were needed to the practice's system for recording and acting on safety alerts.

Safety systems and processes

The practice's systems, practices and processes did not always keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Partial
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
Explanation of any answers and additional evidence:	
We saw evidence that partners and staff had received safeguarding training at a level appropriate for their role. Safeguarding policies were relevant to the practice and contained information to guide staff if they had concerns about a patient's welfare. Staff told us that they were able to access these policies and were able to tell us who the safeguarding lead was.	
We looked at the records of five children on the practice's safeguarding register. There were alerts on these patients' records to identify that they were on the risk register. However, the practice's computer system did not alert staff to all family and other household members of these children. After discussing these findings with the provider, they showed us evidence that appropriate alerts had been applied.	
We looked at the Disclosure and Barring Service (DBS) check records for five members of staff and found that appropriate checks had been made. (DBS checks identify whether a person has a criminal	

Safeguarding	Y/N/Partial
record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).	
All staff who acted as chaperones were appropriately trained and there was a comprehensive policy regarding the role of the chaperone.	

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: We looked at the recruitment records and staff vaccination statuses for five staff members. We found that these records were complete, for example we saw evidence of appraisals, job descriptions and vaccination status for all of these staff members.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: March 2022	Partial
There was a fire procedure. Date of fire risk assessment: May 2022	Yes
Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence: The provider had completed a fire risk assessment in May 2022 which had identified actions that the provider needed to take. For example, the provider needed to ensure self-closers (a device that automatically closes a door) were fitted correctly to all fire rated doors. The risk assessment did not indicate these actions had been completed or give a time frame for completion. After the inspection, the provider wrote to us with evidence that these actions had been completed. We saw a door marked 'fire door keep shut' had been propped open using a hook on the wall. We raised this with the provider and the door was immediately closed. We saw records to confirm staff who were designated fire marshals had received appropriate training. A legionella risk assessment had been carried out in May 2021 by an external contractor who deals with issues specific to legionella (legionella is a bacterium found in water supplies which can cause severe respiratory illness). The risk assessment identified that the overall risk of legionella being present in the practice was low and advised the risk assessment should be repeated in May 2024. The provider showed us evidence that the same contractor attended each month to monitor the temperature of water from hot and cold outlets on the premises. For the period January 2022 – June 2022, we found six temperatures were recorded as being out of the acceptable range identified in the practice's legionella management policy. One outlet was recorded as a possible area of stagnation in	

pipework, which was an optimum condition for bacteria growth. On 17 June 2022 and 30 June 2022, the contractor carried out an inspection of the water tanks and found the water temperatures were below the growth parameters for legionella bacteria. The provider was advised to monitor water temperatures each week until the hot weather subsided, as this was given as an explanation of the previous higher readings from the cold water outlets. However, we did not see evidence to show weekly temperature monitoring had taken place.

We found a SMARTcard (a card that is placed into a computer to allow healthcare professionals to access clinical and personal information appropriate to their role), had been left in a computer in an unlocked, unoccupied room that was accessible to patients and visitors. This was not in line with data protection and could have resulted in an unauthorised person accessing patients' details. We told the provider about our findings and they told us they would raise this incident with the staff member concerned.

Records showed portable appliance testing (PAT) and calibration testing of equipment had been carried out within the last 12 months.

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. Date of last infection prevention and control audit: 14 June 2022	Yes
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:	
The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy.	
We looked at the training records of five members of staff and found all had received training in infection prevention and control relevant to their role.	
The provider had completed an infection prevention and control audit which had identified actions that the provider needed to take. For example, cleaning plans and schedules needed to be implemented. There was an action plan associated with the audit which recorded cleaning plans and schedules were now in place for cleaning staff to follow and were displayed in public areas for staff and patient information.	
Hand sanitising gel was available throughout the practice for patients, staff and visitors to use.	
Clinical waste bins were appropriately stored and secured at the practice.	

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
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
Explanation of any answers and additional evidence: We looked at the training files of five staff members and saw all had received training in basic life support and sepsis management.	

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.	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
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence: Patient referrals to other services under the two week wait system were monitored to help ensure patients received appointments within the necessary timescales. At the time of inspection, we saw all incoming documents on the practice's system had been actioned.	

Appropriate and safe use of medicines

The practice's systems for the appropriate and safe use of medicines, including medicines optimisation, required improvement.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.52	0.83	0.79	Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	7.9%	9.2%	8.8%	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 (01/10/2021 to 31/03/2022) (NHSBSA)	5.81	5.75	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	109.3‰	132.4‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.52	0.62	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	6.6‰	6.9‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Partial
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
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.	Partial
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.	Partial
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.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>We sampled five Patient Group Directions (PGDs) and found one PGD did not contain the name of the organisation and had additional signatory lines that had not been scored through to ensure no further signatures could be added. We told the provider of these findings, who subsequently corrected the error and showed us evidence of the PGD having been completed correctly.</p> <p>We looked at blank prescription forms and pads and found they were stored correctly and tracked through the practice, however we did not see evidence that serial numbers were recorded when supplies were received. After the inspection, the provider wrote to us with evidence that the serial numbers of blank prescription forms were now being recorded when supplies were received.</p> <p>We looked at the records of five patients who had received medicine reviews. We found that none of these patients had received comprehensive reviews. For example, three patients were not up to date with monitoring for the medicines they were prescribed and there was no evidence that this was discussed with or arranged for the patient. One review was for a patient who was not taking a prescribed medicine, we looked but could not see evidence that this had been discussed with the patient. Another review did not review all the medicines prescribed to the patient, however monitoring was up to date. We shared our findings with the provider. The provider subsequently wrote to us with evidence that; two of these patients had now had the required monitoring tests; another patient had</p>	

Medicines management

Y/N/Partial

an appointment booked to review the medicine that was not being taken; another patient had an appointment booked for a medicine review; and another patient had all monitoring undertaken at a hospital.

We looked at the records of three patients prescribed Azathioprine and found that best practice guidance for the management of this high-risk medicine had been followed.

We looked at the records of five patients prescribed a Potassium sparing diuretic and found that best practice guidance for the management of this high-risk medicine had not been followed for one of these patients, who required monitoring tests. We told the provider of these findings who subsequently wrote to us with evidence that the patient had now had the required monitoring tests.

Morphine (a controlled drug) was held by the provider as part of their emergency medicines, however this was not stored in accordance with legal requirements for the storage of such medicines. The provider told us this was because they did not have a key for the internal cupboard within the controlled drugs cabinet. We looked but could not see evidence of a controlled drugs policy including a standard operating procedure (SOP), details of the responsible person or a controlled drugs register. After the inspection, the provider wrote to us with evidence of a controlled drugs policy relevant to the practice, including a SOP, details of the responsible person and a controlled drugs register. The provider told us that they had plans to fit a new lock to the internal cupboard within the controlled drugs cupboard, but we did not see evidence that this had been fitted.

We looked at the emergency equipment used for responding to medical emergencies and saw that the Automated External Defibrillator (AED) was displaying a red cross, indicating 'do not use'. We told the provider, and later in the inspection the provider told us that the batteries in the AED had been changed and showed us that the AED was displaying a green tick indicating it was safe to use. We also found that the packets of two sets of adult defibrillator pads had been opened which goes against best practice guidance. We told the provider who disposed of the open packets and showed us that another two sets of adult defibrillator pads were available, ensuring that adequate emergency equipment was available.

The provider held advanced life support equipment, however, staff told us that there were no staff in the practice trained to use this equipment. After the inspection, the provider told us that the advanced life support equipment had been removed by the practice and sent us evidence to show that the emergency equipment checklist had been updated to reflect this. After the inspection the provider wrote to us to tell us that there was a clinician who worked at the practice who was advanced life support trained. At the time of inspection this staff member worked an average of three sessions per week at the practice.

We looked at the emergency medicines held by the practice and found that the practice did not stock dexamethasone oral solution or soluble prednisolone (used to treat croup in children) or buccal midazolam (used to treat seizures). After the inspection the provider wrote to us with evidence that these medicines had now been purchased for use at the practice.

Records showed that the temperature of one refrigerator used to store medicines had been recorded as being outside of the acceptable limits (of between 2 and 8 degrees centigrade) on two occasions between June 2022 and July 2022. We looked but could not see any evidence of action taken by the provider to ensure the integrity of the medicines stored in the refrigerators had not been compromised. The practice's cold chain policy did not contain any information to instruct staff of the action to take should the refrigerator temperature show as out of range. After the inspection the

Medicines management	Y/N/Partial
<p>practice sent us an incident report form for one of the occasions where the temperature was recorded as being out of range. The incident report form stated that although the refrigerator display showed that the temperature was 8.2 degrees centigrade, the data logger recorded that the temperature had remained within the ideal range. Therefore, the provider determined that the medicines had not been exposed to a temperature beyond the ideal range. We did not see an incident report form for the second occasion where the temperature was recorded as being out of range. The provider wrote to us with evidence that the cold chain policy had been updated to include details of action to take should the temperatures go outside of the ideal range.</p>	

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:	28
Number of events that required action:	28
<p>Explanation of any answers and additional evidence:</p> <p>Staff told us that learning from significant events was shared with them. We saw records that confirmed that learning from significant events was discussed during staff meetings.</p>	

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

Event	Specific action taken
A patient attended for a blood test, however the results of this test were recorded on a different patient who had a similar name. The error was discovered when the wrong patient was contacted with the results.	Both patients were made aware of the error and all incorrect information was removed from the patient record. The blood test was repeated. An alert was added to the records of both patients to help ensure that staff thoroughly checked patient details. Staff involved in the incident received additional training. The incident was discussed in a staff meeting.
Baskets were kept in reception for patients to place samples in. These samples were collected by the laboratory. A basket full of samples was found after the last laboratory pick up for the day.	The samples had to be discarded as a further laboratory collection was not available on the day. Patients were told of the error and asked to repeat the samples. The baskets were removed and patients were asked to give the sample to reception staff. The incident was discussed in a staff meeting.

Safety alerts	Y/N/Partial
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There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: We looked at the records of five patients who had been prescribed hydrochlorothiazide (used to treat fluid retention) and found that one of these patients had not been informed of the increased skin cancer risk associated with the use of this medicine. After the inspection the provider wrote to us with evidence that they had unsuccessfully attempted to contact this patient and told us that they would continue to attempt contact to book a review appointment.	

Effective

Rating: Requires Improvement

We rated the practice as Requires Improvement for providing effective services because:

- Patients' needs were assessed, but care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- Improvements in performance related to childhood immunisations and cervical screening were required.

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

Effective needs assessment, care and treatment

Patients' needs were assessed, but care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Partial
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
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes

Explanation of any answers and additional evidence:

Patients with some long-term conditions, such as hypothyroidism, were receiving relevant reviews. However, we found that improvements were required to some reviews of patients with asthma, chronic kidney disease, diabetes and patients prescribed gabapentinoids.

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. The provider worked with local care homes to carry out weekly in-person and virtual ward rounds.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Influenza, 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.
- 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. A care navigator worked with the provider to facilitate this.
- 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 could book appointments with a mental health nurse.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long-term conditions.

Findings

- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- We saw evidence that patients with hypothyroidism had received the appropriate monitoring tests in line with best practice guidance.
- We looked at the records of five patients with asthma who had been prescribed two or more courses of rescue steroids in the last 12 months. There was a repeat prescription error for one patient who was receiving two preventative inhalers per month. Another patient required a steroid card. We shared our findings with the provider who wrote to us with evidence to show the prescription error had been corrected and the second patient had been issued a steroid card.
- The clinical searches that were run as part of our inspection identified two patients with Chronic Kidney Disease (CKD) Stage 4 or 5 who had not had the required monitoring in the last nine months. We shared our findings with the provider who subsequently wrote to us with evidence that both patients had now received the required monitoring tests.

- We looked at the records of five patients who were diagnosed with diabetic retinopathy and found three of them had not had the required monitoring. Two of these patients had not had their recent test results discussed with them and one had not had the risks of a prescribed medicine explained to them. We shared our findings with the provider who wrote to us after the inspection with evidence that two of these patients had now had their recent test results discussed with them. The third patient had an appointment booked to discuss the risks of their prescribed medicine.
- We looked at five patients identified as having a potential missed diagnosis of diabetes. Three of these patients had not had the required monitoring. One patient had not had their recent blood test results discussed with them, one needed to have a blood test and one had not been coded correctly as having diabetes. The provider wrote to us after the inspection with evidence that all patients had been contacted to arrange appointments for the necessary monitoring tests and discussion of results.
- Records showed that five patients prescribed gabapentinoids (used to treat seizures and nerve pain) had not had a review in the last 12 months, as per best practice guidance. After the inspection, the provider wrote to us with evidence that all of these patients had been booked appointments for the appropriate medicine review.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	92	113	81.4%	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) (NHS England and Improvement)	113	116	97.4%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	113	116	97.4%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	112	116	96.6%	Met 95% WHO based target

The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	107	127	84.3%	Below 90% minimum
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Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments
<p>Childhood immunisations were carried out in line with the national childhood vaccination programme.</p> <p>The provider was aware that two of the indicators for uptake rates were lower than the target of 90% (percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) and Hepatitis B; and percentage of children aged 5 who have received immunisation for measles, mumps and rubella). The provider told us that clinical staff had contacted the parents of children who had not had vaccinations, to encourage attendance and discuss any concerns that parents may have.</p>

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	71.5%	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)	56.2%	63.4%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	67.9%	68.1%	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)	43.4%	56.4%	55.4%	No statistical variation

Any additional evidence or comments
<p>Published results showed that the uptake for cervical cancer screening was below the 80% target for the national screening programme. The provider told us that in an attempt to increase uptake for cervical screening they regularly reviewed the updated figures and sent recall letters/text messages to remind patients of the need to book an appointment and offered appointments outside of working hours. Staff told us they made attempts to engage with patients who were reluctant to attend for cervical screening, listened to their concerns and answered any questions patients had about the process.</p>

Data published in 2022 showed an improvement in results. This data showed that the uptake rate for cervical cancer screening was 73.9%, although this was still below the 80% target for the national screening programme.

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

We saw evidence of three clinical audits the provider had completed in the last 12 months. For example, the practice had completed an audit of patients over the age of 64 who were prescribed citalopram 40 mg or escitalopram 20mg. Four patients were identified who required a change in the dosage of their prescribed medicine. All of these patients were consulted and the dose of their medicine was lowered as per best practice guidance. This audit was completed in July 2022 and stated that a follow up audit would be completed in six months' time. Therefore, at the time of inspection there had not been a second cycle to this audit.

Clinical audit activities were limited to one cycle only. This meant that the provider was unable to demonstrate improvement in quality and safety as a result of audit activity.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
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
Explanation of any answers and additional evidence: We looked at the recruitment records of five members of staff and saw evidence of annual appraisals for all of these staff members.	

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

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: We saw that information was available for patients in the waiting room. For example, information on external bodies who offered smoking cessation, mental health and sexual health services.	

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.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We looked at the records of ten patients with DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) decisions. We found there were clearly documented reasons for the DNACPR decisions that were not discriminatory or based on assumptions about the person's quality of life, and there was a record of a discussion with the person (and their representative, where appropriate).</p>	

Caring

Rating: Requires Improvement

We rated the practice as Requires Improvement for providing caring services because:

- The latest National GP Patient Survey results had deteriorated and showed that the practice was performing significantly lower than the local and national averages for indicators regarding patient experience.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. However, some feedback from patients was 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
NHS reviews website	There were 38 reviews on the NHS website. 25 of these reviews were positive about the practice. Positive comments were mainly regarding support from GPs and reception staff, quality of service and access to appointments. 10 reviews were negative about the practice. The negative comments were mainly regarding difficulty accessing appointments and prescriptions. Three reviews contained mixed feedback.
Experience shared directly with CQC via our website	There were 18 comments received by CQC, all of these gave negative feedback. These comments mainly referred to difficulty accessing appointments.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	85.1%	88.2%	89.4%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	82.5%	87.2%	88.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	94.5%	95.4%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	55.9%	80.2%	83.0%	Significant Variation (negative)

Any additional evidence or comments

The practice was aware of the published national GP patient survey results. They had identified that they had received negative feedback from patients about access to appointments which was contributing to patients' negative feedback about the overall experience of their GP practice.

A new telephone system was introduced in January 2022. This system allowed the practice to monitor call activity, advised patients of alternative options (for example, the use of eConsult), increased the number of telephone lines, and allowed patients to request a callback so that they did not have to wait in the telephone queue. The new system also supplied useful data to practice staff, for example they were able to see how long patients had been waiting in the telephone queue and assign staff to answer the telephone in order to reduce waiting times. The practice had also appointed a new reception supervisor and additional reception staff.

Data published on the GP survey website (for surveys results from 2022) showed a decline in results, in relation to 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 – 69.7% (CCG average 82.1%, national average 84.7%).
- 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 - 69.5% (CCG average 80.8%, national average 83.5%).
- Stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to - 90.8% (CCG average 92%, national average 93.1%).
- Responded positively to the overall experience of their GP practice - 32.9% (CCG average 66.8%, national average 72.4%).

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

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

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	92.3%	93.1%	92.9%	No statistical variation

Any additional evidence or comments

Data published on the GP survey website (for surveys results from 2022) showed a decline in results, in relation to 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 86.9% (CCG average 89%, national average 89.9%).

	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

Carers	Narrative
Percentage and number of carers identified.	The practice had identified that there were 295 carers on the practice list (2% of the practice population).
How the practice supported carers (including young carers).	The practice held a register of the patients who had been identified as carers. They were supported by the social prescriber through regular contact via the telephone.

How the practice supported recently bereaved patients.	Alerts were placed on the records of patients who were recently bereaved. The social prescriber contacted these patients via telephone to offer support.
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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

Responsive

Rating: Requires Improvement:

We rated the practice as Requires Improvement for providing responsive services because:

- The latest National GP Patient Survey results had deteriorated and showed that the practice was performing significantly lower than local and national averages for several indicators regarding access to the practice.

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:	
The practice had a hearing loop for use by people with hearing aids.	
The practice was wheelchair accessible and we saw that the reception desk was lowered for improved access for people who use wheelchairs.	

Practice Opening Times

Day	Time
Opening times:	
Monday	7am-6.30pm
Tuesday	7.30am-7.30pm
Wednesday	8am-7.30pm
Thursday	7am-6.30pm
Friday	7.30am-7.30pm
Appointments available:	
Monday	7am-6.30pm
Tuesday	7.30am-7.30pm
Wednesday	8am-7.30pm
Thursday	7am-6.30pm
Friday	7.30am-7.30pm

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.
- Longer appointments were available for people with complex needs and multiple conditions.
- Appointments were available outside of school hours so that school age children did not need to miss school in order to receive care and treatment.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travelers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travelers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. For example, patients with a learning disability were asked if they would like an appointment at the start or end of the day, when fewer people were in the practice.
- Patient toilets were available that included ones that were suitable for people with mobility issues.
- Purpose built baby changing facilities were available.
- A hearing loop was available at the practice reception to assist patients who were hard of hearing or deaf.
- Outside of the practice's working hours, services were delivered to patients by Medway On call Care (MedOCC).

Access to the service

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

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Partial
There were systems in place to support patients who face communication barriers to access treatment	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes

Explanation of any answers and additional evidence:

There were multiple appointment types available, including face to face, telephone and video consultations. Patients were able to book appointments in person, on the telephone and via eConsult (online). Staff told us that where patients required assistance, they would support patients to complete eConsult forms. The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.

On the day of inspection, we looked at the practice's appointment system and found that the next available face to face appointment with a GP was on 22 July 2022, the next available telephone appointment with a GP was on 22 July 2022 and the next available face to face appointment with a nurse was on 8 August 2022.

However, the latest published results from the national GP patient survey showed that patients' satisfaction with access to appointments, appointment times, appointments offered and overall experience of making an appointment, had deteriorated and remained lower than local and national averages.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	19.8%	N/A	67.6%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	34.8%	66.6%	70.6%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	35.5%	63.1%	67.0%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	59.2%	80.7%	81.7%	Variation (negative)

Any additional evidence or comments

The provider was aware of the published National GP patient survey results. The practice had introduced a new telephone system in January 2022 and conducted their own patient surveys since implementation. Most recently, patient data was collected in June and July 2022 and appeared to show positive feedback. This unverified data showed that:

- The percentage of patients who stated that they had found it very easy or easy to get through to the practice via telephone in the last month was 75.4% (107 out of 142 patients).

- The percentage of patients who had to wait 10 minutes or less in the queue for their call to be answered was 83.5% (116 out of 139 patients).
- The percentage of patients who stated that their experience accessing the practice had improved since February 2022 was 77.9% (109 out of 140 patients).

Data published on the GP survey website (for surveys results from 2022) showed a decline in results, in relation to 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 telephone – 5% decline (national average 52.7%).
- Responded positively to the overall experience of making an appointment - 20.9% (CCG average 48.6%, national average 56.2%).
- Were very satisfied or fairly satisfied with their GP practice appointment times - 27.9% (CCG average 48.2%, national average 55.2%).
- Were satisfied with the appointment (or appointments) they were offered – 54.6% (CCG average 68.2%, national average 56.2%)

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	35
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	5
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
Explanation of any answers and additional evidence:	
There was a complaints notice in the waiting room, advising patients of actions to take if they wished to make a complaint.	
We saw evidence that the practice held quarterly complaints review meetings where all staff members were invited to attend and discuss learning from complaints received.	

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient was referred to a specialist at Medway Maritime Hospital, however the referral was completed incorrectly so there was a delay in the referral process.	The provider apologised to the patient for the error and the resulting delay. The referral was completed correctly and staff received additional training.

<p>A patient had difficulties getting through to the practice on the telephone and accessing a face to face appointment.</p>	<p>This complaint was received before the implementation of the new telephone system. The provider apologised for the lack of appointments, explained that they were aware of issues with the telephone system and advised that a new system would be introduced in January 2022.</p>
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Well-led

Rating: Requires Improvement:

We rated the practice as Requires Improvement for providing well-led services because:

- Processes for managing risks, issues and performance required improvement.

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.	Yes
Explanation of any answers and additional evidence: There was a clear leadership structure and most staff told us that they felt supported by management. However, some staff members told us that they would like more support from the leadership team, in particular when dealing with patients who were verbally aggressive. We raised this with the provider who told us that they were aware of the issues with these patients. There had been changes to the practice management team over the last 12 months. The provider told us the new practice management team were supportive to staff, had regular check ins with them and encouraged staff to take breaks and have de-briefs following incidents with patients who had become verbally aggressive.	

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: We saw that the practice mission statement was available in the waiting room.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	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.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes

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

Source	Feedback
Interviews with staff	Staff told us that they were able to raise concerns and felt that the management team was approachable. Staff told us that there were good relationships between managers and staff and that they felt supported.
Staff feedback forms	<p>We received 14 staff feedback forms. Most of the feedback received from staff was positive, particularly regarding support from management, approachable leaders, and good patient care. Staff told us that feedback that had been given had been acted upon, for example a recommendation had been made to extend the appointment times for complex patients, the provider told us that this had been actioned.</p> <p>There were also some negative comments within the staff feedback forms. Some staff felt that; there weren't enough clinical and reception staff; feedback was not always listened to and acted upon; and that communication within the practice could be improved.</p>

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
Explanation of any answers and additional evidence:	

Practice governance policies and documents were implemented and available to all staff through the practice's shared drive on the computer system. Staff told us that they knew how to access practice policies.

Managing risks, issues and performance

Processes for managing risks, issues and performance required improvement.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Partial
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
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:	
<p>Our inspection identified that improvements were required in relation to the management of risks from:</p> <ul style="list-style-type: none"> • Legionella. • The management of patients with some long-term conditions. • Medicines management (PGDs, prescribing of some high-risk medicines, management of controlled drugs, management of medicines that required refrigeration and the lack of availability of some emergency medicines that were required to be held in the practice). • The practice's computer system not alerting staff of all family and other household members of children that were on the risk register. <p>After we told the provider about these findings from our inspection, we saw evidence to show that they took immediate action to address management of risks from:</p> <ul style="list-style-type: none"> • The management of patients with some long-term conditions. • Medicines management (PGDs, prescribing of some high-risk medicines, management of medicines that required refrigeration and the lack of availability of some emergency medicines that were required to be held in the practice). • The practice's computer system not alerting staff of all family and other household members of children that were on the risk register. <p>The provider had an action plan to address management of risks from:</p> <ul style="list-style-type: none"> • Legionella. • Management of controlled drugs. 	

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

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

Appropriate and accurate information

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

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence:	
The practice had a patient participation group (PPG). The PPG had previously reported that the practice weren't responsive to ideas, therefore, the provider told us that they had arranged a meeting in August 2022 to discuss concerns and look to recruit additional PPG members.	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	
We saw evidence of meetings held by the practice where complaints and significant events were discussed, and actions taken and lessons learned were shared.	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ‰ = per thousand.