

## Inspection Evidence Table

Horsmans Place Partnership

(1-565604154)

**Inspection Date: 5 and 6 April 2023**

Date of data download: 10/03/2023

## Overall rating: Good

At our previous inspection on 17 May 2022, we rated the practice as Inadequate.

At this inspection, we found that improvements had been made. We rated the practice as Good because:

- Safeguarding policies had been reviewed and updated and were relevant to the practice.
- The practice's computer system alerted staff of all family and other household members of children that were on the risk register.
- Recruitment checks were carried out in accordance with regulations and practice policy. This included evidence that Disclosure and Barring Service (DBS) checks had been carried out by the practice.
- Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance.
- Staff had received training in the identification of signs and symptoms of sepsis.
- We saw evidence of formal clinical supervision and audit of the prescribing of non-medical prescribers.
- Learning from significant events was shared with staff.
- There were effective systems for the management of safety alerts.
- 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.
- Patients with long-term conditions received appropriate reviews.
- The provider carried out quality improvement activity.
- Staff worked together and with other organisations to deliver effective care and treatment.
- Staff treated patients with kindness, respect, and compassion. Feedback from patients was positive about the way staff treated people.
- Staff helped patients to be involved in decisions about care and treatment.
- Leaders had taken action to ensure the quality, safety and performance of the service.
- There were clear systems to support good governance.
- The practice had processes for managing issues, risks and performance.

# Safe

# Rating: Good

At our previous inspection on 17 May 2022, we rated the practice as Inadequate for providing safe services.

At this inspection, we found that improvements had been made. We rated the practice as Good for providing safe services because:

- Safeguarding policies had been reviewed and updated and were relevant to the practice.
- The practice's computer system alerted staff of all family and other household members of children that were on the risk register.
- Recruitment checks were carried out in accordance with regulations and practice policy. This included evidence that Disclosure and Barring Service (DBS) checks had been carried out by the practice.
- Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance.
- Staff had received training in the identification of signs and symptoms of sepsis.
- We saw evidence of formal clinical supervision and audit of the prescribing of non-medical prescribers.
- Learning from significant events was shared with staff.
- There were effective systems for the management of safety alerts.

## Safety systems and processes

**The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.**

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:  The practice had designated safeguarding leads. All staff knew how to identify and report concerns. There were safeguarding policies that were accessible to staff and outlined who to contact if staff had concerns about a patient's welfare. Staff told us their responsibilities for how to report concerns were clear.  We looked at the training records of 5 staff members and found that all staff were up to date with safeguarding training appropriate to their role.  The practice had a safeguarding register. The practice's computer system alerted staff of children that were on	

the risk register as well as family and other household members of children on the risk register.

There were regular meetings with other healthcare professionals where support for children on the risk register was discussed.

There were notices around the practice and in clinical rooms advising patients that chaperones were available. We saw that staff who acted as chaperones were trained for the role.

We saw that staff had received Disclosure and Barring Service (DBS) checks (DBS checks identify whether a person has a criminal 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).

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
Explanation of any answers and additional evidence:	
We looked at the vaccination records of 5 members of staff and found staff vaccination was maintained in line with current guidance.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: 27/09/2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: 27/06/2022	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	
We saw the provider had completed a health and safety risk assessment on 27 September 2022. This risk assessment identified actions that needed to be completed. For example, the provider needed to keep up to date records of portable appliance testing (PAT). Records showed PAT had taken place on 26 November 2022. The provider was able to demonstrate all actions identified in the risk assessment had been completed.	
The provider had completed a fire risk assessment on 27 June 2022. This risk assessment identified actions that needed to be completed. For example, the provider needed to ensure that the practice's fire safety policy included measures for persons with mobility issues. Records showed the provider had produced an emergency evacuation plan for people with disabilities. The provider was able to demonstrate all actions identified in the risk assessment had been completed.	

Records showed calibration testing of equipment had been carried out within the last 12 months.

The provider had a fire evacuation plan, completed testing of the fire alarm system and carried out fire drills. The most recent fire drill took place on 7 November 2022.

**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.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: December 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<p>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 5 staff members and saw they had received appropriate training in infection prevention and control (IPC).</p> <p>The provider had completed an infection prevention and control risk audit in December 2022. This audit identified actions the provider needed to take and included evidence of action taken to resolve these. For example, one of the treatment rooms was audited on 6 December 2022 where a drawer was found to be cluttered. This drawer was cleared and re-audited on 7 December 2022, where it was found to be free from clutter.</p>	

**Risks to patients**

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

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

Explanation of any answers and additional evidence:

There was an induction system for all new staff.

The practice had a comprehensive business continuity plan for major incidents such as; power failure or building damage. The plan included emergency contact numbers for staff and other relevant external contacts.

We looked at the training records of 5 members of staff and found all these staff members had completed basic life support training appropriate to their role.

Training records showed that staff had received training in the recognition and management of patients with potential sepsis appropriate to their role.

Keypad locks from the waiting room to the back of reception were not always in use. Staff at the practice told us about several incidents where patients had been verbally and physically aggressive to staff. After the inspection the provider wrote to us with evidence the keypad locks were now in use.

An external company visited the practice on 8 June 2022 to assess the risks of legionella (legionella is a bacterium found in water supplies which can cause severe respiratory illness). Water sampling was carried out as part of the visit. The presence of legionella was not detected at the premises.

We saw evidence that the temperature of water from hot and cold water outlets had been monitored and recorded from 27 February 2023 to 24 March 2023. There were 13 occasions where the temperature of the outlets was recorded as being outside of the recommended ranges. The out-of-range recordings were always from mixer taps (where hot and cold water were combined within one outlet). This had been reported to the management team who had contacted an external company for guidance on how to resolve the issue.

**Information to deliver safe care and treatment**

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

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

Explanation of any answers and additional evidence:

We looked at the management of documents within the practice's systems. We found there were 2283 tasks that appeared to have not been actioned. The tasks dated from January 2022 to March 2023. We looked at 2 tasks and found they had been completed but not marked as such. We shared our findings with the provider. The provider then sampled 24 outstanding tasks and found that all had been actioned, filed and completed. The provider had an action plan whereby they would aim to check all outstanding tasks within the next week. In the future, all staff will be informed that once they action a task they must then mark it as complete. The practice had a plan for the practice manager (or a designated member of the practice's administrative team) to access the task system once per week, to check all tasks have been completed.

We looked at the management of lab results within the practice's systems and found 2004 lab results appeared to have not been actioned. The lab results dated from October 2021 to March 2023. We looked at 2 lab results and found action had been taken for these patients but not marked as such. We shared our findings with the provider. The provider then sampled 30 patients and found all these results had been reviewed and actioned by a GP. It appeared that duplicate results had been sent to the provider by the laboratory. The provider had an action plan whereby they would aim to check all outstanding lab results in the next week and to raise these issues with the laboratory carrying out the tests. The provider would continue to utilise a buddy system to ensure results assigned to GPs would be checked during periods of absence. Any urgent results were sent to the duty doctor to check and action. GPs were expected to access results weekly to ensure all are filed. In the future, the practice had a plan for the practice manager (or a designated member of the practice's administrative team) to access the task system once per month to check for any unfiled results and inform a GP to action.

**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	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) (NHSBSA)	0.65	0.85	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)	8.7%	8.6%	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)	5.35	5.75	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	100.2‰	133.3‰	129.7‰	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)	1.30	0.60	0.58	Tending towards variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	6.6‰	6.8‰	6.8‰	No statistical variation

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

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

Explanation of any answers and additional evidence, including from clinical searches.

The provider held medical oxygen, a defibrillator and emergency medicines on site. We saw evidence of regular monitoring of these.

The provider had four refrigerators for the storage of vaccines. The temperatures of these refrigerators were monitored and recorded regularly.

We looked at five Patient Group Directions (PGDs) and found that staff had the appropriate authorisations to administer medicines.

We found that blank prescription forms were stored and managed in line with best practice guidance.

We saw evidence that a GP partner completed regular prescribing reviews for non-medical prescribers working at the practice. An up-to-date prescribing policy was available to staff.

We found 40 patients were prescribed methotrexate (an immunosuppressant). All these patients had the required monitoring in line with best practice guidance.

We found 1151 patients were prescribed ACE inhibitor or Angiotensin II receptor blocker (medicines used to treat high blood pressure or heart failure). We found 39 patients had not had the required monitoring tests. We reviewed the records of 5 of these patients and saw all had been sent multiple reminders to attend for monitoring tests. The provider used various forms of communication, including phone call and text message reminders. To encourage patients to attend for monitoring tests, the amount of medicine prescribed was reduced for patients who had not had the required tests.

**Track record on safety and lessons learned and improvements made**  
**The practice learned and made improvements when things went wrong.**

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	19
Number of events that required action:	19
Explanation of any answers and additional evidence:	
We looked at 4 significant events that had been recorded in the last 12 months. We saw the events had been	



investigated, escalated to the GP partners where necessary, discussed in staff meetings and action taken. We saw lessons learned were shared in staff meetings.

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

Event	Specific action taken
Patient details on cervical screening results were incorrect. This resulted in patients needing to return for a repeat cervical screening test.	This incident was investigated and was found to have occurred due to a technical issue with the printer when printing patient labels. The issue with the printer was resolved. The patients affected received explanations and apologies. The incident was discussed in a staff meeting, where staff were reminded to check details with patients and to ensure these are correctly recorded on samples.
A virus was detected in the practice's computer systems.	The incident was immediately reported by the staff member who downloaded the virus in error. The IT team removed the virus and found no damage had been caused to the practice's computer systems. Staff were reminded of their responsibilities when using the internet on the practice's computers. This incident was discussed and learning shared at a staff meeting.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We found 29 patients of childbearing age had been prescribed a teratogenic drug (a drug which is known to cause foetal abnormalities when a person is exposed to during pregnancy). We reviewed 5 of these patients and saw evidence that the patient had been informed of the risks of these medicines in line with best practice guidance.</p> <p>At our inspection in October 2022, we found that one patient was prescribed a combination of medicines to reduce blood clotting and another to reduce stomach acidity. A Medicines and Health products Regulatory Agency (MHRA) alert from December 2014 advised that these medicines should not be prescribed together.</p> <p>At this inspection, we reviewed this patient and found that they were no longer on this combination of medicines.</p>	

## Effective

## Rating: Good

At our previous inspection on 17 May 2022, we rated the practice as Requires Improvement for providing effective services.

At this inspection, we found that improvements had been made. We rated the practice as Good for providing effective services because:

- 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.
- Patients with long-term conditions received appropriate reviews.
- The provider carried out quality improvement activity.
- Staff worked together and with other organisations to deliver effective care and treatment.

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

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	

Patients with long-term conditions such as hypothyroidism, diabetic retinopathy, and chronic kidney disease, were receiving relevant reviews. The provider had an action plan to improve the monitoring of patients with asthma, and those prescribed benzodiazepines or Z drugs (groups of medicines prescribed for anxiety, sleeping problems and other disorders).

## 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.
- 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.

## Management of people with long term conditions

### Findings

During our inspection, we completed a series of searches on the practice's clinical records system. These searches were completed with consent and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance.

We looked at 5 medicine reviews and found that 4 reviews had been completed to a high standard. One patient had not had all their medicines reviewed. We shared our findings with the provider. The provider showed us evidence that the patient had been sent multiple reminders to attend for a review but had not yet attended.

We reviewed 5 patients who had been prescribed 2 or more courses of rescue steroids. We found that 1 patient had their condition managed in line with best practice guidance. Two patients appeared to have not had an adequate assessment at the time of prescribing rescue steroids and another 2 patients had not had an annual asthma review. We shared our findings with the provider. On the day of inspection, the provider showed us evidence that the two patients without an adequate review at the time of prescribing had now either been reviewed or scheduled for review. The provider also showed us evidence that the two patients who had not had an annual asthma review had either been reviewed or contacted for review.

We reviewed 5 patients with hypothyroidism. Four of these patients had the required monitoring in line with best practice guidance. One patient had not had the required monitoring; however, we saw evidence the provider had sent multiple reminders in the form of letters and phone calls to request the patient attend for the monitoring tests.

We reviewed 5 patients identified as having a potential missed diagnosis of Chronic Kidney Disease (CKD) stage 3,4 or 5 and found that all patients had been managed in line with best practice guidance.

At our previous inspection in October 2022, our clinical searches identified 1 patient as having a potential missed diagnosis of diabetes. At the previous inspection the patient was overdue blood monitoring tests. We reviewed this patient at this inspection and found that blood monitoring tests remained overdue. However, we saw evidence of multiple reminders sent to the patient to attend for tests as well as a record of an explanation given to the patient of the risks to the patient should they not receive the appropriate monitoring tests.

The provider was aware there were a high number of patients identified as having been prescribed 10 or more prescriptions for benzodiazepines or Z drugs. Our clinical searches identified 99 patients who met this criteria. The clinical team at the practice, including GPs and clinical pharmacists, were currently working together to look at reducing the prescribing of these medicines. We reviewed 4 patients and found these patients had their medicines managed in line with best practice guidance.

We reviewed 5 patients with diabetic retinopathy (diabetic retinopathy is a complication of diabetes, caused by high blood sugar levels damaging the back of the eye. It can cause blindness if left undiagnosed and untreated). Four of these patients had the required monitoring in line with best practice guidance. One patient appeared to have not had a recent review of their medication. We shared our findings with the provider. The provider showed us evidence that a medicine review had taken place since their most recent test result, however this had not been coded correctly. The provider then corrected this error.

- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- 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.

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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	64	76	84.2%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	86	97	88.7%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	89	97	91.8%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	89	97	91.8%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	82	107	76.6%	Below 80% uptake

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

Childhood immunisations were carried out in line with the national childhood vaccination programme. NHS England results (published in March 2022) showed uptake rates were higher than the World Health Organisation (WHO) minimum target of 90% for 2 indicators, and below the target of 90% for 3 indicators. The provider was aware of these published results and told us that uptake rates were monitored. Patients who had not attended for immunisations were contacted by staff at the practice. Alerts were placed on the records of patients who had not attended, so that this could be discussed when attending appointments for other matters.

Cancer Indicators	Practice	SICBL average	England	England comparison
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	28.6%	63.5%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	60.6%	68.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	54.7%	57.5%	54.9%	No statistical variation
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). (30/09/2022 to 30/09/2022) (UKHSA)	65.0%	N/A	80.0%	Below 70% uptake

### Any additional evidence or comments

Published results showed that the provider's uptake for cervical cancer screening as of September 2022 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 reminders to patients of the need to book an appointment; and used opportunistic appointment bookings, when a patient attended the practice for other matters.

### Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years: The provider sent evidence of clinical audits that were part of an overarching programme. Records showed that 10 clinical audits had been carried out in the last 2 years. For example, the provider completed an audit on patients prescribed direct oral anticoagulants (DOACs). This audit looked at whether patients had received the required monitoring tests for these medicines. The first cycle of the audit, completed in September 2021 suggested that improvements were required. For example, 79% of patients had liver function tests and full blood counts recorded within the last 12 months. Only 5.6% of patients had their body weight documented. The second cycle of the audit was completed in June 2022. This audit found that 98.6% of patient now had liver function tests and full blood counts recorded within the last 12 months. Also, 97.9% of patients had their weight documented. The provider had achieved these improvements by dedicating additional administration time to check patients every 3 months and recall for monitoring tests where appropriate. The provider kept and reviewed a spreadsheet and included alerts on patient records. Reminders were also placed on patient's prescriptions to increase patient awareness of the requirement for monitoring tests.	

### Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y

There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was a programme of essential training including, fire safety, infection prevention and control and mental capacity act. Records viewed showed that staff had completed this training.</p>	

### Coordinating care and treatment

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

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

### Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw posters in the practice waiting room which gave information about how patients could manage their own health. For example, services providing support to parents who were breastfeeding and mental health support. Notices encouraged carers to identify themselves to practice staff.</p> <p>Patients interested in smoking cessation received advice from clinical staff and could self-refer to local support. A dietician was available in the practice to provide advice on healthy eating.</p>	



**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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence. We reviewed 3 patient records where a DNACPR decision had been recorded. This identified that where a DNACPR decision had been recorded, patient views had been sought and respected. We saw there was a clear rationale for the decision that was not discriminatory nor based on assumptions about the person's quality of life. DNACPR decisions were shared with Out-Of-Hours and ambulance services.	

# Caring

**Rating: Good**

## Kindness, respect and compassion

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

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

## National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who 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)	73.2%	82.1%	84.7%	Tending towards 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)	69.5%	80.8%	83.5%	Tending towards 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)	89.8%	92.0%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	45.7%	66.8%	72.4%	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.

The provider had identified that increased capacity of GP appointments would be beneficial to the practice

population. The provider had employed locum GPs which had resulted in an additional 150 available appointments per week as of May 2022. The rotas of GP partners were amended in January 2023 which resulted in an additional 64 available appointments per week.

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

**Any additional evidence**

The provider had carried out a survey of patients who had appointments with a pharmacy professional in April 2023. At the time of inspection, the provider had received 5 responses from patients. The survey asked patients whether they felt at ease, listened to and whether they were given clear explanations. Respondents gave positive answers to all questions. The provider had a plan to review and audit the results once the response timescale had passed.

**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.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

**National GP Patient Survey results**

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who 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)	85.3%	89.0%	89.9%	No statistical variation

**Any additional evidence or comments**

National GP patient survey data was collected between January and April 2022. Feedback about the practice from the national GP patient survey was positive and in line with local and England averages

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y

Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	The practice had identified that there were 22 carers in the practice (0.2% of the practice population). The practice had a dedicated member of staff who potential carers could be signposted to for support. There were signs in the practice and information on the practice website encouraging patients to identify themselves as carers.
How the practice supported carers (including young carers).	There was a social prescriber who liaised with carers and directed them to local services.
How the practice supported recently bereaved patients.	Bereaved patients were sent a card and received a telephone call from a GP. Support was offered by the practice and patients were signposted to appropriate organisations for further support.

### Privacy and dignity

**The practice respected patients' privacy and dignity.**

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

## Responsive

## Rating: Requires Improvement

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

- Patients experienced difficulty accessing the practice by telephone.
- The practice had taken action to address these issues. However, the provider had not yet collected patient feedback to demonstrate the effectiveness of the action taken.
- Minutes from a recent Patient Participation Group meetings showed there was concern from patients regarding access to services.

### Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	
The layout of the practice meant that all areas on the ground floor were accessible to people using wheelchairs or mobility scooters. A hearing loop was available at reception. Toilets were accessible to people with limited mobility and there were designated baby changing facilities. The practice did not have a lift to the first floor of the practice, however patients with limited mobility were given appointments in clinical rooms on the ground floor.	

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	8am – 11.30am and 2pm – 6.30pm
Tuesday	8am – 11.30am and 2pm – 6.30pm
Wednesday	8am – 11.30am and 2pm – 6.30pm
Thursday	8am – 11.30am and 2pm – 6.30pm
Friday	8am – 11.30am and 2pm – 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.
- There was a medicines delivery service for housebound patients.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional nurse appointments were available until 6.30pm for school age children so that they did not need to miss school.
- 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, Travellers and those with a learning disability.
- The practice held a register of patients receiving palliative care.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

### Access to the service

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

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

Explanation of any answers and additional evidence:

There were multiple appointment types available, including face to face and telephone consultations. Patients were able to book appointments in person, on the telephone and via online submissions. We were told the online submission system was available for 30 minutes each day. We were told access to the online submission system was limited as there were currently insufficient staff to deal with patient demand where this was accessible for longer than 30 minutes each day.

Patients were able to make appointments in person at the practice. However, staff at the practice told us this was to be stopped in the future in an attempt to direct all patients to make appointments via telephone.

Minutes from the most recent patient participation group (PPG meeting) in January 2023 showed patients were concerned about the long waits on the telephone and the lack of available appointments.

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 the next available:

- Face to face appointment with a GP was 6 April 2023
- Face to face appointment with a nurse was 11 April 2023
- Telephone appointment with a GP was 6 April 2023.

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	21.6%	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)	32.2%	48.7%	56.2%	Tending towards 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)	36.0%	48.4%	55.2%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	52.4%	68.3%	71.9%	Variation (negative)

## Any additional evidence or comments

National GP patient survey data was collected between January and April 2022. The provider was aware that feedback about the practice from the national GP patient survey was lower than local and England averages. There were 126 respondents to the GP patient survey for Horsmans Place Partnership (1% of the practice population).

The provider told us that they had received negative feedback about the practice's telephone systems, in particular the length of time taken to get through to a member of staff at the practice. In response to this feedback, the provider installed a new telephone system on 27 February 2023. This system included various options for patients. A patient needing a GP or nurse appointment was directed to a receptionist, whereas someone with a prescription query or request for a medical report was directed to leave an answerphone message for the appropriate team to respond to.

The updated telephone system provided information to administrative staff regarding the number of people waiting in the telephone queue and how long they had been waiting for. The management team were able to allocate additional staff to answer the telephones to reduce the waiting time of callers.

The provider had collected data on the telephone systems in the first 6 weeks of implementation. Unverified data showed that approximately 70% of calls were now directed to answerphones for prescription and other queries. The provider told us this freed up the telephone lines for receptionists to answer calls requesting urgent and routine appointments. The call abandonment rate (where the caller hung up the phone before being connected to a member of staff) ranged from 5-12% of calls over the 6-week period.

Unverified data showed the average call waiting time during this 6-week period was between 52 and 84 seconds. The maximum call waiting time for this 6-week period was between 1 hour 14 mins and 3 hours 31 minutes.

The provider had not collected feedback from patients regarding the new telephone systems. One review on the NHS.uk website (dated March 2023) referenced improvements to access to the practice via telephone.

Source	Feedback
NHS.uk website (formerly NHS Choices)	<p>There were 12 reviews on the NHS website, the feedback from 6 of these reviews was positive, 1 was mixed and 5 were negative.</p> <p>Positive feedback referred to:</p> <ul style="list-style-type: none"> <li>• Polite, professional, and helpful administrative staff</li> <li>• Improvements to access to the practice via telephone</li> <li>• Respected and helpful clinical staff</li> </ul> <p>Negative feedback referred to:</p> <ul style="list-style-type: none"> <li>• Long waits for routine appointments.</li> <li>• Difficulty accessing repeat prescriptions.</li> </ul>
Experience shared with CQC directly via our website	CQC received 15 comments, which raised concerns about access to appointments, long waits on the telephone and delays in receiving test results.



## 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.	15
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.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient needed to have a dressing changed and stitches removed. The patient was initially told this could be done at the practice; however this information was incorrect and the patient needed to travel to a different location within the Primary Care Network.	The patient was contacted via telephone. The practice manager apologised to the patient and gave a full explanation of the procedure for change of dressings and removal of stitches. This complaint was discussed at a staff meeting and the minutes were shared to ensure staff were aware of the correct process.
A patient was referred for tests, but there was a delay in their appointment for these tests.	The provider investigated this complaint and found that there had been an administrative error. A task to create the referral had not been raised with the correct staff member. The patient received an apology from the practice and the referral was made. The complaint was discussed with the staff members involved to ensure the correct process was understood. The complaint was discussed at a practice meeting.

## Well-led

## Rating: Good

At our previous inspection on 17 May 2022, we rated the practice as Inadequate for providing well-led services.

At this inspection, we found that improvements had been made. We rated the practice as Good for providing well-led services because:

- Leaders had taken action to ensure the quality, safety and performance of the service.
- There were clear systems to support good governance.
- The practice had processes for managing issues, risks and performance.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:  There was an interim practice manager who had been employed at the practice since August 2022. There were plans to recruit a permanent practice manager once the contract for this manager ended, however there was currently no end date to the interim practice manager's employment.  Staff had received training to allow them to increase their skills and knowledge, for example administration staff have been trained to carry out some managerial duties. Practice nurses had been supported to become non-medical prescribers.	

### Vision and strategy

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

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

Explanation of any answers and additional evidence:  
 The provider had a statement of purpose which reflected the vision of the practice.

**Culture**

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

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

Explanation of any answers and additional evidence:  
 We reviewed the training records of 5 staff members and found that all had completed training in equality and diversity.  
 Staff told us they had the opportunity to share their views, raise concerns and staff feedback was acted upon. For example, a staff meeting took place each week. Reception staff requested that clinical staff could communicate with receptionists when running late, so patients could be made aware of any delays to their appointments.

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

Source	Feedback
Staff feedback forms and staff interviews.	Feedback from staff was positive with staff commenting that leaders were visible and approachable. Staff told us the practice environment was supportive and they felt comfortable raising concerns with the management team.

## 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.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence:  We looked at 20 governance documents and found that they were up to date. The provider had a system to ensure the documents were reviewed regularly.	

## 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.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: Our inspection identified improvements were required to the management of risks in relation to: <ul style="list-style-type: none"><li>• Security of staff at the practice, in particular ensuring staff only areas were not accessible to patients and visitors.</li><li>• The management of documents and results within the practice's computer systems.</li><li>• The monitoring of patients who had been prescribed 2 or more courses of rescue steroids.</li><li>• The monitoring of patients prescribed benzodiazepines or Z drugs.</li><li>• The uptake of cervical cancer screening.</li><li>• The uptake of childhood immunisations.</li><li>• Legionella management.</li></ul> However, we found the provider either already had an action plan to address the risks mentioned above or	

provided evidence following the inspection which showed appropriate action had been taken in relation to these risks.

The provider had a comprehensive action plan which detailed how they were monitoring and improving systems and processes for the management of patients prescribed benzodiazepines or Z drugs; the uptake of cervical cancer screening; the uptake of childhood immunisations; and legionella management.

After the inspection the provider wrote to us with evidence that they had taken appropriate action on the security of staff at the practice; the management of documents and results within the practice's computer systems; and the monitoring of patients who had been prescribed 2 or more courses of rescue steroids.

### 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.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y

### Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	
The practice continued to operate throughout the pandemic providing a range of appointments including; face	

to face, video and telephone consultations, as well as home visits.

**Engagement with patients, the public, staff and external partners**

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had an active patient participation group (PPG) who held meetings with practice representatives approximately every 3 months. PPG meetings had restarted in 2022 following a suspension of meetings during the pandemic. We saw examples where the PPG had shared ideas for improvement and actions that the provider had taken in response to these. For example, members of the PPG raised concerns about access to appointments. This was via the telephone system, as they experienced long waits on the telephone, as well as the number of appointments available each day. Practice staff responded to say the number of available GP appointments had increased by 64 each week and the new telephone system was due to be implemented which would improve telephone access.</p> <p>PPG members also suggested that the practice should advertise PPG meetings via the practice website. There was a form for prospective members to complete, however this did not include up to date information of the staff in the practice. Meeting minutes were available online for a PPG meeting in 2019, but not for the most recent meeting in January 2023.</p>	

**Continuous improvement and innovation**

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Complaints and significant events were used to make improvements. We saw evidence that learning from complaints and significant events was shared with staff. Staff told us they were invited to meetings where learning was shared.</p>	

## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.