Suffolk & North East Essex
Training Hub

CQC Inspection Pack

Suffolk & North East Essex
Integrated Care System

CAN DO
HEALTH & CARE

Table of Contents

CQC Inspection: Practice

CQC Inspection of Practice Name

Pre inspection information required where possible, if files are too large to send or scan please indicate and we can review them when we are on site.

Evidence below is required as part of your inspection. Please follow instructions on following pages and send information in separate emails for each numbered section.

This template has been devised to assist you in collating evidence as part of your inspection. If you would find it easier for the inspector to view any of the requested evidence as part of the on-site inspection, please discuss this with your inspector.

Staff records will be looked at on site to avoid sending personal information but if this is required by the inspector, we have a secure process to follow. Please discuss with your inspector.

Please follow instructions on following pages and send information in separate emails for each numbered section.

- Practice ODS code.
- List size.

Date information should be returned by; XXXXXXXXX

Email address of who to send information to; XXXXX

Other:

- **PPG contact details** – calls will be made before or at onsite inspection
- **Care home contact details –** calls will be made before inspection.
- **To collect feedback from patients;** Please give link to patients and put onto your website Give Feedback on Care

Please give/or attach full staff list with email addresses

Staff member name	Role	WTE	Email address.

Please title the email:

EMAIL 1 GOVERNANCE, POLICIES AND PROCEDURES: **PRACTICE NAME**

EMAIL 1 **GOVERNANCE, POLICIES AND PROCEDURES** **Please attach:**	**Embedded or attached document.**	**Attached Y/N** **(Please state reason if not attached)**
Statement of purpose		
Copy of Major incident/business continuity		
Medical emergencies policy		
Chaperone policy		
Induction process		
Online services policy Information leaflet for online services		
Access policy		
Registration policy (incl access to medical records)		
Home visits/care home protocol		
Process for supporting carers		
Process for bereaved patients		
ICO registration certificate		
Provider liability/MD insurance		
Safety and drug alerts process and evidence of management and actions.		
Policy and process for ensure staff are recruited safely including DBS and registration checks.		
Policy and process to ensure practice oversight of other staff not directly employed by the practice who have access to patients or their records.		
Process for supervision and competency oversight of clinical staff including staff with a prescribing qualification.		
Policy for ensuring PGDs and PSDs are appropriately reviewed and signed.		

Please title the email:

EMAIL 2 TRAINING: **PRACTICE NAME**

EMAIL 2 **TRAINING** **Please attach:**	**Embedded or attached document.**	**Attached Y/N** **(Please state reason if not attached)**
List of staff and their extended role(s) eg cervical screening, diabetes, immunisations		
Policy of training for staff and process to manage and monitor		
Matrix of staff training which should include; • Cervical screening training • Child and adult safeguarding detailing the appropriate level undertaken • BLS and anaphylaxis • Chaperone Training • Fire safety including fire marshals • Immunisation training • Infection prevention and control • Mental capacity act training • Sepsis and emergency procedures • Evidence that staff undertaking reviews of patients with long term conditions have received appropriate\ate training. • Evidence that staff undertaking extended roles such as triage, minor illness have received appropriate training. • Other training		

Please title the email:
EMAIL 3 SAFEGUARDING**: Practice Name**

EMAIL 3 **SAFEGUARDING** **Please attach:**	**Embedded or attached document.**	**Attached Y/N** **(Please state reason if not attached)**
Safeguarding adults policy		
Safeguarding children policy		
Sample of minutes of MDT meetings		
Policy/process to ensure information is shared with others such as coding of medical records.		

Please title the email:
EMAIL 4 RISK ASSESSMENTS**:Practice Name**

EMAIL 4 **RISK ASSESSMENTS** **Please attach:**	**Embedded or attached document.**	**Attached Y/N** **(Please state reason if not attached)**
Summary of risks undertaken		
Latest fire risk assessment and any action log		
Evidence and date of fire extinguisher check		
Evidence of latest service for emergency lights and alarm test		
Copy of the latest fire drill and actions taken.		
Sample of fire alarm checks undertaken in the month of XXXXXX		
Latest health and safety risk assessment and any action log		
Latest legionella risk assessment and water temperature checks undertaken in the month of XXXXX		
Copy of any risk assessments the practice has taken such as wheelchair access, monitoring of waiting areas etc.		
Equipment calibration dates and copy of certificate		
PAT testing dates and copy of certificate		
Evidence of immunisation status of staff.		

Please title the email:

EMAIL 5 INFECTION PREVENTION AND CONTROL: **Practice Name**

EMAIL 5 **INFECTION PREVENTION AND CONTROL** **Please attach:**	**Embedded or attached**	**Attached Y/N** **(Please state reason if not attached)**
Latest Infection control policy		
Latest Infection prevention control audit and action lo		
Copies of any meetings where IPC has been discussed, any shared learning and changes since last inspection		
Cold chain policy including number and location of vaccine fridges		
Copy of the temperature recordings for week beginning XXXXXXXX		

Please title the email:

EMAIL 6 SIGNIFICANT EVENTS, COMPLAINTS AND COMPLIMENTS: **Practice Name**

EMAIL 6 **SIGNIFICANT EVENTS, COMPLAINTS AND COMPLIMENTS** **Please attach:**	**Embedded or attached**	**Attached Y/N** **(Please state reason if not attached)**
Significant events policy		
Complaints policy and leaflet available to patients		
A summary of significant events within the last 12 months, including evidence of actions you have taken, learning you have applied, and improvements made as a result.		
A summary of complaints received within the last 12 months, including evidence of actions you have taken, learning you have applied, and improvements made as a result.		
Sample of meetings minutes where significant events and /or complaints have been discussed in past 6 months.		
Sample of compliments received in past 6 months.		

Please title the email:

EMAIL 7 EVIDENCE OF QUALITY IMPROVEMENT WORK : **Practice Name**

EMAIL 7 **EVIDENCE OF QUALITY IMPROVEMENT WORK** **Please attach:**	**Embedded or attached**	**Attached Y/N** **(Please state reason if not attached)**
Summary of the quality of care you provide for your population groups.		
Details of how you have monitored and improved care and treatment, such as • A summary of clinical audits from the last two years. • Details of two complete full-cycle audits including actions taken and outcomes achieved.		
Summary of any other quality improvement work undertaken over the last two years.		
Evidence of how you have collected, analysed and responded to patient feedback during the last 12 months, including examples of actions taken.		
If not included above – If you have undertaken your own Patient survey and not included above – results of the survey and action log		
Evidence of how you have collected, analysed and responded to staff feedback during the last 12 months, including examples of actions taken.		

Please title the email:

EMAIL 8 PATIENT RECORD KEEPING AND MEDICINES: **Practice Name**

EMAIL 8 **PATIENT RECORD KEEPING AND MEDICINES** **Please attach:**	**Format** **Word, Excel etc**	**Attached Y/N** **(Please state reason if not attached)**
Discharge (medicine reconciliation) process and any audits/checks undertaken.		
Policy and process for the management of repeat prescriptions and medicine reviews.		
Patient workflow/summarising/coding in medical records policy/process and any audits/checks undertaken.		
Number of patient records that have not been fully summarised.		

Please title the email:
EMAIL 9 DATA FOR THE REPORT: **Practice Name**

EMAIL 9 **DATA FOR THE REPORT** **Please attach:**	**Format** **Word, Excel etc**	**Attached Y/N** **(Please state reason if not attached)**
NHS health checks data, how many eligible, how many offered, how many completed in last 12 months		
Learning Disability check data, how many eligible, how many offered, how many completed in last 12 months		
Total number and percentage of carers on the practice register- Number of young carers on the practice register- Examples of support given to carers.		
Patient Participation Group – • Numbers • Virtual or face to face • Agenda's • Minutes/notes		

Please title the email:
EMAIL 10 EVIDENCE RELATING TO DISPENSARY: **Practice Name INS2-XXXXXXXXXX**

EMAIL 10 **EVIDENCE RELATING TO DISPENSARY** **Please attach:**	**Embedded or attached**	**Attached Y/N** **(Please state reason if not attached)**
General dispensing Standard operating procedure		
Controlled drugs dispensing and record keeping Standard operating procedure		
Preparation of monitored dosage packs Standard operating procedure		
Delivery and / or collection point service Standard operating procedure		
Dispensary audits (time period tbc)		
Risk assessment - Delivery or collection service		
Risk assessment - Dispensary access and security of medicines		
Risk assessment - Preparation of monitored dosage packs		

Further Guidance regarding Safeguarding Training from CQC Inspector 2023

When carrying out the remote interviews with clinicians and management staff the GP specialist advisor asks the following questions to ascertain the practical application of their training.

Safeguarding systems, processes and practices were developed, implemented and communicated to staff.

- How are safeguarding concerns managed/escalated?
- Can you provide any examples of reporting safeguarding concerns?
- How does the practice deal with patients with FGM or at risk of FGM?
- Does the practice have registers? How are these updated? Are they reconciled regularly with LA? Are patients on these registers regularly reviewed?
- Ask who leads meetings and then have discussion with the lead.
- Review register/safeguarding records. Have patient records got alerts and family member records have appropriate codes and alerts – are they using codes that will be transferrable.
- What happens for children turning adult? Or when taken off formal child protection plan but still possibility of safeguarding concerns?

If CQC choses a member of staff to look at more closely would a learning log which would include their e learning certificate would be sufficient? An e-learning certificate evidence is fine

Care Quality Commission

Inspection Evidence Table

Inspection Date:

Date of data download:

The Evidence Table is generated using the same data as GP Direct Monitoring Approach Dashboard. This template includes all domains. Inspectors will need to delete the sections that are not relevant to their inspection.

The data presented in the Evidence Table should NOT be changed or removed in any way. The data has been statistically analysed via a robust methodology and outliers have been identified using this process. If data is missing from the ET inspectors should NOT attempt to add their own data or identify outliers. Other members of the inspection team should be made aware that the data should not be altered.

Using unvalidated/unverified data
Unvalidated or unverified data refers to nationally collected clinical data which has been provided by the practice and has not been published; and therefore, has not been verified as being accurate by the data owner (e.g. UK Health Security Agency, NHS Digital, NHS England and Improvement)
If the practice has provided the inspector with unverified data that is more recent than the data presented in the Evidence Table, then inspectors can do the following:
1. Inspectors can add this data to the narrative text box beneath the relevant pre-populated data. Inspectors can include information about performance over time but MUST ensure it is looking at the same populations and state that it is unvalidated data. Details should also include the source of the data, and the time period it represents. If the data supplied is a percentage, it is important to provide the underlying numbers that the percentage is based upon.
2. Inspectors MUST ensure that the data being added is for the relevant indicator and also that the correct indicator definition is being used. For example, the cervical screening indicator used in the ET comes from the UKHSA definition, not the QOF definition. The childhood immunisation indicators used in the ET are from the UKHSA's COVER data and are not from the GP immunisation target payments under the Childhood Immunisation Directed Enhanced Service (available in Open Exeter)
3. Unvalidated data is NOT comparable to data from previous years and no statistical comparison should be attempted. For example, if the data item has a percentage that would indicate an outlier in 2020/21, this does not mean that same percentage would be an outlier in 2021/22.
4. Unverified data should not be used to support a ratings judgement or decision in relation to the effective key question. Decisions should only take into consideration the published outcomes data.
5. Relevant unverified data could be referred to in the well-led key question as part of efforts practices may be making to effect improvements. This should include how the provider has considered the population demographics, the needs of their population and disease prevalence.

Clinical searches
Clinical searches are routinely used on inspection to identify patients for further review. Where the

records review identifies no risk/good practice/risk or potential risk to patients this should always be referred to in the relevant sections within the ET, giving a brief description.
It is important not to provide patient level descriptors and describe in terms that will be accessible to the public reading our reports. Any wording of examples should reflect the records reviewed and reviews completed.
DELETE the red text throughout the document.

Overall rating: add overall rating here

If the overall rating is Inadequate, RI or outstanding, or if the rating has moved to Good from a previous rating of Inadequate, RI or Outstanding give a brief explanation of the reasons for the rating.
For example, for practices moving from outstanding to good the following example could be used:
At this inspection, we found that those areas previously regarded as outstanding practice were now embedded throughout the majority of GP practices. While the provider had maintained this good practise, the threshold to achieve an outstanding rating had not been reached. The practice is therefore now rated (good/requires improvement/inadequate).

Safe Rating: add rating here

If the rating is Inadequate, RI or outstanding, or if the rating has moved to Good from a previous rating of Inadequate, RI or Outstanding give a brief explanation of the reasons for the rating.
For example, for practices moving from outstanding to good the following example could be used:
At the last inspection in (add date) we rated the practice as outstanding for providing safe services because:
• Add sentence to say why.
At this inspection, we found that those areas previously regarded as outstanding practice were now embedded throughout the majority of GP practices. While the provider had maintained this good practise, the threshold to achieve an outstanding rating had not been reached. The practice is therefore now rated (good/requires improvement/inadequate) for providing safe services.
The data presented in the Evidence Table should NOT be changed or removed in any way.

Safety systems and processes

The practice had/did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	.
Partners and staff were trained to appropriate levels for their role.	.
There was active and appropriate engagement in local safeguarding processes.	.
The Out of Hours service was informed of relevant safeguarding information.	.

There were systems to identify vulnerable patients on record.	.
Disclosure and Barring Service (DBS) checks were undertaken where required.	.
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.	.
Explanation of any answers and additional evidence:	

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

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	.
Date of last assessment:	.
There was a fire procedure.	.
Date of fire risk assessment:	.
Actions from fire risk assessment were identified and completed.	.
Explanation of any answers and additional evidence:	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met/not met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	.
Infection prevention and control audits were carried out.	.
Date of last infection prevention and control audit:	.
The practice had acted on any issues identified in infection prevention and control audits.	.
The arrangements for managing waste and clinical specimens kept people safe.	.
Explanation of any answers and additional evidence:	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	.
There was an effective induction system for temporary staff tailored to their role.	.
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	.
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.	.
There were enough staff to provide appointments and prevent staff from working excessive hours	.
Explanation of any answers and additional evidence:	

Information to deliver safe care and treatment

Staff had/did not have the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. 1	.
There was a system for processing information relating to new patients including the summarising of new patient notes.	.
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	.
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	.
There was a documented approach to the management of test results and this was managed in a timely manner.	.
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	.
Explanation of any answers and additional evidence: 1 Review of patient records in relation to the clinical searches identified that care records were/were not managed in line with current guidance. Where not, this wording could be used- For example, history, examination, management plans, safety netting and follow up were not adequately documented.	

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.70	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). (01/07/2021 to 30/06/2022) (NHSBSA)	5.7%	8.9%	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 (01/01/2022 to 30/06/2022) (NHSBSA)	5.01	5.77	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	125.1‰	132.5‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.58	0.61	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	4.8‰	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.	.
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	.
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	.

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.	.
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. 1	.
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.	.
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. 2	.
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	.
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	.
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.	.
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	.
For remote or online prescribing there were effective protocols for verifying patient identity.	.
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.	.
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	.
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	.

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

Where examples are given. Note more specific details. For example, Review of X clinical records, identified by the clinical search, for patients taking a medicine to treat XXX, showed that XX patients had/had not received appropriate monitoring:

1 Medicine reviews – where the clinical review of patients notes has identified poor quality medicine reviews (as described by GP SpA or CQC MOT) this should be referenced here. Examples could include: The provider recorded medicine reviews had been conducted without documenting the outcomes from the review and without addressing required monitoring or changes to treatment that should have been identified during a comprehensive review.

2 High Risk Medicines and DMARD medicines– where the clinical review of patients' notes has identified deficiencies in the monitoring of high-risk medicines, this should be referenced here. Examples, could include- The provider was not able to demonstrate that it remained safe to prescribe medicines to patients where specific, frequent, monitoring was required. Patients were having blood tests arranged via the hospital but the provider was not routinely recording that these indicated it was safe to continue prescribing the medicines.

This is just one potential situation that might be uncovered. This example will need to be adjusted based on the reviews completed. Please speak to a member of the CQC Medicines Optimisation Team if you would like some help in reflecting what was found on inspection in this area.

These examples will need to be adjusted based on the alerts examined and findings from patient record reviews. Further support can be found on the ‘GP inspection tools for SPAs and Inspectors’ teams channel. Defining risk from GP clinical searches for inspectors. DO NOT provide patient level descriptors and describe in terms that will be accessible to the public reading our reports.

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	.
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	.
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	.
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patents. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	.
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	.
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer’s recommendations to ensure they remained safe and effective.	.
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	.

If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	.
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	.
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	.
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	.
Explanation of any answers and other comments on dispensary services:	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong/did not have a system to learn and make improvements when things went wrong.

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

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

Event	Specific action taken
.	.
.	.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. 1	.
Staff understood how to deal with alerts.	.

Explanation of any answers and additional evidence:
We saw examples of actions taken on recent alerts, for example, regarding sodium valproate.
1 Where the examination of patient records from the clinical searches have identified deficiencies in the system of responding to safety alerts, we need to give examples of the risk. For example, *The provider was unable to demonstrate that all relevant safety alerts had been responded to. We saw that patients remained on combinations of medicines that increased their risk of heart problems without anything in their records to indicate this had been identified and the risk discussed with the patient or alternative treatments considered*.
This example will need to be adjusted based on the alerts examined.

Effective Rating: add rating here

If the rating is Inadequate, RI or outstanding, or if the rating has moved to Good from a previous rating of Inadequate, RI or Outstanding give a brief explanation of the reasons for the rating.
For example, for practices moving from outstanding to good the following example could be used:
At the last inspection in (add date) we rated the practice as outstanding for providing effective services because:
• Add sentence to say why.
At this inspection, we found that those areas previously regarded as outstanding practice were now embedded throughout the majority of GP practices. While the provider had maintained this good practise, the threshold to achieve an outstanding rating had not been reached. The practice is therefore now rated (good/requires improvement/inadequate) for providing effective services.

The data presented in the Evidence Table should NOT be changed or removed in any way.

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/were not assessed, and care and treatment was/ was not 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.	.
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.1	.
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.2	.

We saw no evidence of discrimination when staff made care and treatment decisions.	.
Patients' treatment was regularly reviewed and updated.3	.
There were appropriate referral pathways to make sure that patients' needs were addressed.	.
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	.
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	.
The practice prioritised care for their most clinically vulnerable patients	.
Explanation of any answers and additional evidence:	

Effective care for the practice population

Findings

Add examples of findings here including positive and negative findings from clinical searches (for example):

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

1 Where the clinical review of patient records has identified that patients' ongoing needs are not fully assessed, this should described. For example, *the clinical search identified XX patients. From these we reviewed XX records, of which XX were not always reviewed in line with national guidance, which would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm.*

2 Where the clinical examination of patient records has identified that patients are not appropriately followed up this should be described.

3 Where the clinical review of patients with long term conditions identified deficiencies in the process of review this should be described.

These examples will need to be adjusted based on the records examined.

1 and 3 could also include searches relating to medicines usage – review of gabapentinoids and benzodiazepines/Z drugs and overuse of SABA inhalers. Please speak to the medicines team for advice if required.

Management of people with long term conditions

Findings

Add examples of findings here:

- Add relevant positive or negative evidence from clinical searches/records reviews of people with long term conditions. (Any examples will need to be adjusted based on the records examined).

[1] Where the clinical review of patient records has identified that patients' ongoing long term condition needs are not fully assessed this should be described. This could include missing diagnosis, diabetes and chronic kidney disease. For example, *X patients with blood tests indicating they may have an undiagnosed long-term conditions which had not been identified or recorded in their records, were not always reviewed in line with national guidance, which would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm.*
[2] Where the clinical examination of patient records has identified that patients are not appropriately followed up this should be described. This may include asthma exacerbation and long-term conditions. For example, *Patients requiring high dose steroid treatment for severe asthma episodes were not always followed up in line with national guidance to ensure they received appropriate care*
[3] Where the clinical review of patients with long-term conditions identified deficiencies in the process of review this should be described. For example, *Patients with long term conditions were not always reviewed to ensure their treatment was optimised in line with national guidance; we saw that X patients with poorly controlled diabetes/thyroid disease were not reviewed to ensure they could be offered treatments or monitoring to improve control*.

Examples of other findings to include:

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- 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) (01/04/2020 to 31/03/2021)(NHS England and Improvement)	33	34	97.1%	Met 95% WHO based target

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)	43	44	97.7%	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)	42	44	95.5%	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)	41	44	93.2%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021)(NHS England and Improvement)	46	54	85.2%	Below 90% minimum

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

Any additional evidence or comments
Add additional information or evidence relating to effective care for children and young people here:.

Cancer Indicators	Practice	SICBL average	England	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). (30/06/2022 to 30/06/2022)(UKHSA)	82.3%	N/A	80.0%	Met 80% target
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)	68.4%	56.4%	55.4%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021)(UKHSA)	75.2%	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)	72.9%	68.0%	66.8%	N/A

Any additional evidence or comments
Add additional information or evidence relating to effective care for children and young people here:.

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/There was limited monitoring of the outcomes of care and treatment.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	.
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	.
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	.
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years: Add findings here	

Any additional evidence or comments
Include any relevant information relating to quality improvement activities.

Effective staffing

The practice was able/ unable 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.	.
The practice had a programme of learning and development.	.
Staff had protected time for learning and development.	.
There was an induction programme for new staff.	.
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.	.
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	.

There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	.
Explanation of any answers and additional evidence:	

Coordinating care and treatment

Staff worked/ did not work 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.	.
Patients received consistent, coordinated, person-centred care when they moved between services.	.
Explanation of any answers and additional evidence:	

Helping patients to live healthier lives

Staff were / were not 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.	.
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	.
Patients had access to appropriate health assessments and checks.	.
Staff discussed changes to care or treatment with patients and their carers as necessary.	.
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	.
Explanation of any answers and additional evidence:	

Any additional evidence or comments
.

Consent to care and treatment

The practice always obtained / was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	.
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	.
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. 1	.
Explanation of any answers and additional evidence, including from clinical searches: 1 *Our clinical review of notes where a DNACPR decision had been recorded, this identified……where possible the patients views had been sought and respected……we saw that information had been shared with relevant agencies.* If these phrases can't be used, then this needs to be described also.	

Caring — Rating: add rating here

If the rating is Inadequate, RI or outstanding, or if the rating has moved to Good from a previous rating of Inadequate, RI or Outstanding give a brief explanation of the reasons for the rating.
For example, for practices moving from outstanding to good the following example could be used:
At the last inspection in (add date) we rated the practice as outstanding for providing caring services because:
• Add sentence to say why.
At this inspection, we found that those areas previously regarded as outstanding practice were now embedded throughout the majority of GP practices. While the provider had maintained this good practise, the threshold to achieve an outstanding rating had not been reached. The practice is therefore now rated (good/requires improvement/inadequate) for providing caring services.
The data presented in the Evidence Table should NOT be changed or removed in any way.

Kindness, respect and compassion

Staff treated/ did not treat patients with kindness, respect and compassion.
Feedback from patients was positive/ negative about the way staff treated people.

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

Patient feedback	
Source	**Feedback**
.	.

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)	92.7%	82.1%	84.7%	No statistical variation
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)	87.2%	80.8%	83.5%	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 (01/01/2022 to 30/04/2022)	96.7%	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)	81.7%	66.8%	72.4%	No statistical variation

Any additional evidence or comments
Use this box to describe what action has been taken to improve any indicators that are lower than local or national averages .

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

Any additional evidence
.

Involvement in decisions about care and treatment
Staff helped patients to be involved in decisions about care and treatment / patients were not 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.	.
Staff helped patients and their carers find further information and access community and advocacy services.	.
Explanation of any answers and additional evidence: Easy read and pictorial materials were available.	

Source	Feedback
Interviews with patients.	.

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)	93.4%	89.0%	89.9%	No statistical variation

Any additional evidence or comments
Use this box to describe what action has been taken to improve any indicators that are lower than local or national averages .

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

Carers	Narrative
Percentage and number of carers identified.	.

How the practice supported carers (including young carers).	.
How the practice supported recently bereaved patients.	.

Privacy and dignity

The practice respected / did not always respect patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	.
There were arrangements to ensure confidentiality at the reception desk.	.
Explanation of any answers and additional evidence:	

Responsive Rating: add rating here

Where the rating remains good you can use this example of text here:
The data and evidence we reviewed in relation to the responsive key question as part of this inspection did not suggest we needed to review the rating for responsive at this time. Responsive remains rated as Good.

If the rating is Inadequate, RI or outstanding, or if the rating has moved to Good from a previous rating of Inadequate, RI or Outstanding give a brief explanation of the reasons for the rating.
For example, for practices moving from outstanding to good the following example could be used:
At the last inspection in (add date) we rated the practice as outstanding for providing responsive services because:
• Add sentence to say why.
At this inspection, we found that those areas previously regarded as outstanding practice were now embedded throughout the majority of GP practices. While the provider had maintained this good practise, the threshold to achieve an outstanding rating had not been reached. The practice is therefore now rated (good/requires improvement/inadequate) for providing responsive services.
The data presented in the Evidence Table should NOT be changed or removed in any way.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs/ Services did not meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	.

The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	.
The facilities and premises were appropriate for the services being delivered.	.
The practice made reasonable adjustments when patients found it hard to access services.	.
There were arrangements in place for people who need translation services.	.
The practice complied with the Accessible Information Standard.	.
Explanation of any answers and additional evidence:	

Practice Opening Times	
Day	**Time**
Opening times:	.
Monday	.
Tuesday	.
Wednesday	.
Thursday	.
Friday	.
Appointments available:	.
Monday	.
Tuesday	.
Wednesday	.
Thursday	.
Friday	.

Further information about how the practice is responding to the needs of their population
Add some detail here (including how patients needs had been met): some suggestions below, add your own/remove as appropriate • 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. • In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred. • 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 7pm on a Monday 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 was open until 8.15pm on a Monday and Friday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available Saturday and Sunday 10am until 1pm.
• The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers 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 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/ were not able to access care and treatment in a timely way.

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

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	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)	78.6%	N/A	52.7%	Significant variation (positive)

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)	70.1%	48.6%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	64.5%	48.2%	55.2%	No statistical variation
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)	77.2%	68.2%	71.9%	No statistical variation

Any additional evidence or comments
Use this box to describe what action the practice has taken to improve access .

Source	Feedback
For example, NHS Choices	.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care/ Complaints were not used to improve the quality of care.

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

	Y/N/Partial
Information about how to complain was readily available.	.
There was evidence that complaints were used to drive continuous improvement.	.
Explanation of any answers and additional evidence:	

Example(s) of learning from complaints.

Complaint	Specific action taken

.	.

Well-led Rating: add rating here

If the rating is Inadequate, RI or outstanding, or if the rating has moved to Good from a previous rating of Inadequate, RI or Outstanding give a brief explanation of the reasons for the rating.
For example, for practices moving from outstanding to good the following example could be used:
At the last inspection in (add date) we rated the practice as outstanding for providing well-led services because:
• Add sentence to say why.
At this inspection, we found that those areas previously regarded as outstanding practice were now embedded throughout the majority of GP practices. While the provider had maintained this good practise, the threshold to achieve an outstanding rating had not been reached. The practice is therefore now rated (good/requires improvement/inadequate) for providing well led services.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels / Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	.
They had identified the actions necessary to address these challenges.	.
Staff reported that leaders were visible and approachable.	.
There was a leadership development programme, including a succession plan.	.
Explanation of any answers and additional evidence:	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care. / The practice had a clear vision, but it was not supported by a credible strategy to provide high quality sustainable care.

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

Culture

The practice had a culture which drove high quality sustainable care / The practice culture did not effectively support high quality sustainable care.

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

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

Source	Feedback
.	.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. / The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	.
Staff were clear about their roles and responsibilities.	.
There were appropriate governance arrangements with third parties.	.
There are recovery plans in place to manage backlogs of activity and delays to treatment.	.
Explanation of any answers and additional evidence:	

Managing risks, issues and performance

There were / the practice did not have clear and effective processes for managing risks, issues and performance.

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

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making / The practice did not always act on appropriate and accurate information.

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

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.	.
The provider was registered as a data controller with the Information Commissioner's Office.	.
Patient records were held in line with guidance and requirements.	.
Patients were informed and consent obtained if interactions were recorded.	.
The practice ensured patients were informed how their records were stored and managed.	.
Patients were made aware of the information sharing protocol before online services were delivered.	.

The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	.
Online consultations took place in appropriate environments to ensure confidentiality.	.
The practice advised patients on how to protect their online information.	.
Staff are supported to work remotely where applicable.	.
Explanation of any answers and additional evidence:	

Engagement with patients, the public, staff and external partners

The practice involved / did not involve 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.	.
The practice had an active Patient Participation Group.	.
Staff views were reflected in the planning and delivery of services.	.
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	.
Explanation of any answers and additional evidence:	

Feedback from Patient Participation Group.

Feedback
.

Any additional evidence
.

Continuous improvement and innovation

There were / there was little evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	.
Learning was shared effectively and used to make improvements.	.
Explanation of any answers and additional evidence:	

Examples of continuous learning and improvement

.

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.