

# Care Quality Commission

## Inspection Evidence Table

### Coldharbour Surgery (1-569811916)

Inspection date: 8 January 2019

Date of data download: 13 December 2018

## Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

## Safe Rating: Good

### Safety systems and processes

**The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. However, some improvements to the monitoring of recruitment processes required improvement.**

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Policies were in place covering adult and child safeguarding.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Policies were accessible to all staff.	Yes
Partners and staff were trained to appropriate levels for their role. For example, level three for GPs, locum GPs, nurse practitioners, practice nurses and healthcare assistants. All other staff, including administration staff were trained to level two.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
Systems were in place to identify vulnerable patients on record.	Yes
There was a risk register of specific patients.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required. The practice had decided to check all staff every three years.	Yes

<b>Safeguarding</b>	<b>Y/N/Partial</b>
Staff who acted as chaperones were trained for their role.	Yes
There were regular organised monthly discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers. to support and protect adults and children at risk of significant harm.	Yes

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Yes
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Partial
Staff who required medical indemnity insurance had it in place.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We looked at four staff files and spoke with two members of staff. Staff spoken to said they had been interviewed prior to appointment and asked to provide references. All staff had a recruitment and training folder. All files contained disclosure and barring (DBS) checks, proof of identity, immunisation status and job offer. Two files did not contain evidence that references, or conduct in previous employment had been sought, although both members of staff were known to partners at the practice. For example, both members of staff had worked at the practice for over a year and both had worked regularly at the practice as locums. A risk assessment was immediately written to explain the reasons for employing this member of staff. Two nursing files were inspected but these did not contain evidence that recent registration checks had been completed. This information was immediately sourced. One file did not contain evidence of previous employment history. The provider added that this would be monitored going forward.</p>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 30 December 2018 for both practice and branch	Yes
There was a record of equipment calibration. Date of last calibration: 30 December 2018 for both practice and branch	Yes
Risk assessments were in place for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure in place.	Yes
There was a record of fire extinguisher checks. Date of last check: Weekly checks were performed.	Yes

There was a log of fire drills. Date of last drill: Main practice- December 2018 Branch- Date planned.	Yes
There was a record of fire alarm checks. Date of last check: Weekly checks were performed.	Yes
There was a record of fire training for staff.	Yes
There were fire marshals in place.	Yes
A fire risk assessment had been completed. Date of completion: September 2018	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: Recent building works at both the main practice and branch had resulted in risk assessments for infection control, fire safety and general health and safety being reviewed. The recent risk assessments had not identified any actions. We saw evidence of previous actions being completed.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: January 2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: January 2019	Yes
Explanation of any answers and additional evidence: Recent building works at both the main practice and branch had resulted risk assessments for general health and safety being reviewed. This included legionella risk assessments. No actions had been identified. Contract cleaners kept records of maintenance of water systems.	
Three monthly spot checks of sharps bins and waste management systems had been completed.	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
An infection risk assessment and policy were in place.	Yes
Staff had received effective training on infection prevention and control.	Yes
Date of last infection prevention and control audit: CCG Infection control audit- 2016. Practice infection control audit- December 2018- No actions identified.	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes

The practice used contract cleaners and monitored cleaning schedules. The company kept records of maintenance of water systems.

Actions highlighted during the CCG infection control audit in 2016 had been promptly addressed. Other potential health and safety risks had been addressed during recent building work last year. For example, removal of carpets, introduction of appropriate flooring, handwashing facilities, screening and replacement of splashbacks.

## 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. This was usually covered by existing staff although locum GPs and nurses were sometimes used to cover annual leave and other long-term staff absences. Additional administration staff were employed or offered overtime when required.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
There was equipment available to enable assessment of patients with presumed sepsis or another clinical emergency.	Yes
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
Explanation of any answers and additional evidence: Administration staff had been provided with verbal and written guidance regarding sepsis and said the clinical staff were approachable and responsive where concerns were raised.	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Partial
Referrals to specialist services were documented.	Yes
There was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
All referrals were sent to the Referral Management and Booking service (RMBS) and the information required automatically populated from the clinical system. If any information was missing – the referrals were returned by the RMBS.	

## Appropriate and safe use of medicines

### The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) NHS Business Service Authority - (NHSBSA)	0.82	0.77	0.94	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). (01/10/2017 to 30/09/2018) (NHSBSA)	9.3%	8.4%	8.7%	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national	Yes

Medicines management	Y/N/Partial
guidance.	
Blank prescriptions were stored securely and removed at night. All printers had locks for additional security.	
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process in place for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
At the time of inspection medicine re authorisations were being done by the lead GP. Evidence of the re authorisation was stored within the practice email system and not the patient record. The provider stated that anything of clinical significance, such as changes or adjustments were added to the patient journal.	
Not recording the reauthorisations meant that staff or external healthcare providers who access the computer system could not see that an authorisation had taken place.	
The GP stated that this information would be recorded within the patient record from now onwards.	
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
No controlled drugs were stored on the premises	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols in place for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Yes
There was medical oxygen and a defibrillator on site and systems were in place to ensure these were regularly checked and fit for use.	Yes
There was not a defibrillator on either site at time of inspection. Local arrangements were	Partial

Medicines management	Y/N/Partial
in place with neighbouring practices but an order had been placed for the purchase of this equipment. Evidence was sent to conclude that this equipment was now on site at time of writing the report.	
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases and monthly checklists were maintained to demonstrate this process had been completed. However, we found four items at the main branch that had expired. For example, two syringes had expired in 2017 and 2018 despite records saying these had expiry dates of 2019. We found four needles which had expired in March 2018 and an irrigation fluid which had expired in April 2018. These expiry dates would pose an infection control risk as sterility could not be guaranteed. The equipment was immediately replaced and a significant event process commenced.</p>	

## Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events, although records did not always reflect the level and detail of discussions and learning completed.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information. This was done daily at the clinical meetings and reviewed annually at the staff meetings	Yes
Number of events recorded in last 12 months:	8
Number of events that required action:	8
<p>Explanation of any answers and additional evidence: All events were recorded on a spreadsheet which included headings of 'actions taken', 'discussion' and 'review information'. However, the records did not reflect the detail of discussion that had taken place. For example, six of the eight entries read 'case is discussed in clinicians meeting' but the details of this discussion was not recorded. Conversations with clinical staff detailed the discussions and actions that had taken place.</p>	

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

Event	Specific action taken
Vaccine fridge failure – During the	Practice Manager was alerted when they arrived in the building



premises being refurbished a very low stock was maintained in fridge. It was noticed that fridge was not working. Temperature recorded at time of discovery was 26.8 degrees.	at 9am. Staff were alerted. It was noticed that the plug had been removed. Power source was reinstated. Vaccine manufacturers were contacted to enquire the stability of the vaccines. All vaccines and batch numbers were recorded and destroyed due to stability. The fridge was checked every hour over the weekend and was found to be ok on every occasion. A 'power surge' plug and battery pack was ordered to ensure as much as possible against a power surge/failure.
It was identified that a large number (1100) of correspondences from other health care providers had not correctly been downloaded onto the practice computer system from the NHS mail hub. This included medicine changes, discharge letters and correspondence from referrals.	Once the source of this issue was identified practice staff completed an initial review and drew up an action plan. Staff that were not normally working on Friday and the following week were drafted in to manage the normal day to day work, whilst the others dealt with the backlog. Duplicate correspondences were checked to ensure no additional information had been added to the original documents. A small number of medicine changes were identified but these patients had already come to the practice to discuss the changes of medicines. No harm came to any patients. The issue was reported to the CCG and NHS England.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: Staff were sent safety alerts by email which were then monitored using a 'read receipt' function.	

## Effective

## Rating: Good

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes



Appropriate referral pathways were in place to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>A record of two week wait referrals was maintained.</p> <p>However, the referral process was not always monitored to ensure patients had been provided with an appointment. Practice staff said it was normal practice that the hospital informed the practice if patients did not attend and patients were asked to contact the practice after 10 days if they had not received an appointment.</p> <p>The practice had proactively raised a significant event regarding the delay in referral. The investigation highlighted that there had been a failure in the system. The GP had made the referral, but had not saved it on the system, or written it on the referral log back up. The event was raised when the patient made contact. Action included staff education and the provider completed an audit to show that recent referrals had been processed correctly and sent this to us at the time of writing the report. A new system had also been introduced to continue to monitor this process.</p>	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHSBSA)	1.20	0.97	0.81	No statistical variation

## Older people

## Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>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.</li> <li>The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.</li> <li>Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.</li> <li>Every patient aged 75 and over had a named GP.</li> <li>Nationally reported data showed that outcomes for patients for conditions commonly found in older people were good. For example, 100% of patients aged 75 years or over with a fragility fracture and a diagnosis of osteoporosis were being treated with a bone-sparing agent, compared to the clinical commissioning group average of 97% and the national average of 93%.</li> <li>The practice offered over 75 year patients a health check.</li> </ul>

## People with long-term conditions      Population group rating: Good

### Findings

- Patients with long-term conditions had 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.
- 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 diagnosed with atrial fibrillation were assessed for stroke risk and treated appropriately.
- The practice were community host for patients who have poorly controlled diabetes.
- Nursing staff had lead roles in chronic disease management.
- Patients at risk of unplanned hospital admission were discussed in the quarterly multidisciplinary team (MDT) meetings and at the weekly clinician coffee meetings.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	82.5%	73.3%	78.8%	No statistical variation
Exception rate (number of exceptions).	18.1% (47)	10.0%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	70.4%	72.7%	77.7%	No statistical variation
Exception rate (number of exceptions).	12.7% (33)	7.0%	9.8%	N/A
	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	76.8%	75.4%	80.1%	No statistical variation
Exception rate (number of exceptions).	13.5% (35)	8.7%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	70.2%	74.8%	76.0%	No statistical variation
Exception rate (number of exceptions).	8.4% (21)	2.9%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	90.5%	89.3%	89.7%	No statistical variation
Exception rate (number of exceptions).	22.8% (28)	7.2%	11.5%	N/A
<p>We spoke with the provider about the variation of exception reporting and we looked at patient records. We saw that the decision-making process for excepting patients were appropriate.</p> <p>The provider told us they had a system in place which worked out the QOF algorithms and used a spreadsheet to reduce the number of exception reports. The provider said they thought the higher than average exception reporting rates was due to the closure of local practices and new patients. It had been identified there had been an issue with coding of long term conditions and lack of understanding of the importance of annual review by these patients.</p> <p>We looked at unverified data which showed that recent figures had improved.</p>				

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	82.0%	79.3%	82.6%	No statistical variation
Exception rate (number of exceptions).	2.7% (20)	3.3%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	86.5%	85.0%	90.0%	No statistical variation
Exception rate (number of exceptions).	6.3% (5)	8.7%	6.7%	N/A

## Findings

- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Young people had access to contraception and/or sexual health testing (depending upon age and therefore in considering both Gillick competencies and Fraser Guidelines).

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	62	65	95.4%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	59	76	77.6%	Below 80% (Significant variation negative)
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) (01/04/2017 to 31/03/2018) (NHS England)	62	76	81.6%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	59	76	77.6%	Below 80% (Significant variation negative)

## Any additional evidence or comments

Childhood immunisation uptake rates were recorded as a variation to the World Health Organisation (WHO) targets. The practice were aware of this and had disputed this data with the local clinical commissioning group. They had also identified that there was a transient population which may have contributed towards the figures. It had been identified by the CCG that follow up immunisation and booster rates were lower than average. A working party had been set up to look at ways to attract patients to

return for the boosters and vaccinations for two-year olds.

## Working age people (including those recently retired and students)

Population group rating: Good

### Findings

- 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. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the practice.

Cancer Indicators	Practice	CCG average	England average	England comparison
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) (01/04/2016 to 31/03/2017) (Public Health England)	71.5%	68.9%	72.1%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)	70.5%	64.3%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE)	46.3%	45.8%	54.6%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (PHE)	92.3%	73.2%	71.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE)	35.3%	58.8%	51.6%	No statistical variation

## People whose circumstances make them vulnerable

Population group rating: Good

### Findings

- 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 held a register of patients living in vulnerable circumstances including homeless

people and those with a learning disability.

- 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 reviewed patients living within local care homes.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people and informed vulnerable patients about how to access various support groups and voluntary organisations.

## People experiencing poor mental health (including people with dementia)

**Population group rating: Good**

### Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- There was a system for following up patients who failed to attend for administration of long-term medicines, although documentation regarding this system of review and reauthorisation was not stored within the patient record.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients could access dementia screening and sent a screening questionnaire twice a year to patients at risk to provide early intervention.
- Practice staff worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.
- Staff signposted patients experiencing poor mental health to access various support groups and voluntary organisations, and were in the process of applying to host a local Live Well Coach at the practice. This service offered patients up to six 45-minute face to face sessions in the community to offer signposting and support.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QoF)	100.0%	86.0%	89.5%	Variation (positive)

Exception rate (number of exceptions).	42.9% (39)	6.0%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	97.4%	85.0%	90.0%	No statistical variation
Exception rate (number of exceptions).	14.3% (13)	3.6%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	73.1%	84.4%	83.0%	No statistical variation
Exception rate (number of exceptions).	16.1% (5)	4.7%	6.6%	N/A

#### Any additional evidence or comments

We spoke with the provider about the variation of exception reporting and looked at patient records. We saw that the decision-making process for excepting patients were appropriate.  
The provider continued to monitor this data.

#### Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	555.29	-	537.5
Overall QOF exception reporting (all domains)	8.1%	4.9%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Yes
Quality improvement audits had been performed but clinical audits were either not complete cycles or limited to local medicine improvement audits. The provider was aware of this and explained that this was due to partnership changes, staff illness and refurbishments of both practices. The plan was to restart the programme to complete these cycles in the next few months.	

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

Direct acting oral anticoagulants (DOAC) study. In August 2017, 35 patients had been prescribed DOACs.



Of these, 40% had received appropriate screening. The audit identified 11% of patients required dosage changes. A repeat of the audit in February 2018 showed that 34 patients were currently prescribed DOACs. Of these 79% had received appropriate screening. with 9% identified as requiring dosage changes. (The audit showed the rate of patients screened had improved by 39%).

## 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. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
Staff had access to regular appraisals, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses and nurse practitioners.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes
Staff appraisals were used to assess training needs.	
The competence of nurses and nurse practitioners was assessed by ensuring they had attended professional updates and had completed training. However, there was no overview of referrals and prescribing made by nurse practitioners at the practice. This had been addressed and evidence submitted by the time of writing the report.	
All clinical staff and the practice manager were provided with five days study leave for continuous development. The group of GP practices (Syndicates) were opportunities for further education and development. The practice had protected learning days which were organized by the local Community Education Provider Network (CEPN), an organisation, commissioned by Health Education England.	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
We saw that the practice monitored unplanned admissions and patient attendance at the Emergency department. Data showed a lower than average Emergency department attendance compared to other practices in the locality. Referral rates for dermatology, urology, gynaecology and respiratory were also lower than local averages.	

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	91.3%	93.7%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.6% (7)	0.6%	0.8%	N/A

## 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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Explanation of any answers and additional evidence: Minor surgery consent forms were completed and scanned into the patient computer record.	

## 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.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

### CQC comments cards

Total comments cards received.	8
Number of CQC comments received which were positive about the service.	8
Number of comments cards received which were mixed about the service.	2
Number of CQC comments received which were negative about the service.	0
Comments included positive feedback about the staff being kind, caring and helpful. Patients added that the care and treatment was 'very good', 'excellent' and 'thorough'. There were two negative comments about problems accessing appointments with a chosen GP.	

Source	Feedback
Patient interviews	We spoke with three patients whose feedback matched those in comment cards. Parents said they had never experienced issues with accessing appointments for

their children. Patients said staff were helpful, professional and caring.
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## National GP Survey results

**Note:** The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4899	392	104	26.5%	2.12%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	88.8%	86.0%	89.0%	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 (01/01/2018 to 31/03/2018)	80.1%	84.2%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	99.4%	93.8%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	86.1%	81.3%	83.8%	No statistical variation

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

Any additional evidence
The practice had conducted an independent survey in 2017 to patients who had given an email address to engage with a much larger cohort of the patient population, and not just those who visited the practice regularly. The survey showed that 64.3% of those who answered the survey did not have a long-term

condition and 51.3% were under the age of 50 years. One of the questions showed that 43% of patients thought the service was excellent 31% considered the service very good and 20% good.

As a result of the patient survey staff made some changes:

- The 'form filing and report request' process was simplified
- Raising further awareness of the extended hours hubs.

## Involvement in decisions about care and treatment

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

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

## National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	96.3%	90.2%	93.5%	No statistical variation

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

Carers	Narrative
Percentage and number of	The practice had recently completed a review of patients coded on the

carers identified.	computer system as carers as a higher than expected number had been identified. It was found that a previous practice had identified patients whose employment was listed as carer. A new search had highlighted 33 patients as being carer for a relative. (1%)
How the practice supported carers.	Once carers had been identified they were offered a carers pack which contained information about where to access support. Posters were also displayed in waiting areas, signposting where support information could be accessed. New patients were asked at registration if they had caring responsibilities.
How the practice supported recently bereaved patients.	Bereaved patients were sent a condolences card and contacted by the GP where appropriate.

## Privacy and dignity

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

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes

## Responsive

**Rating: Good**

### Responding to and meeting people's needs

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

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Yes
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Yes

### Practice Opening Times

Day	Time	
Opening and appointment times with GP and nurses:		
	Main practice	Branch
Monday	8am-8pm (appointments until 7.15pm)	8am- 2pm
Tuesday	8am-8pm (Nurse until 6pm and GP until 7.15pm)	8am- 6.30
Wednesday	8am-6.30pm	8am- 6.30
Thursday	8am-2pm	8am- 6.30
Friday	8am-6.30	8am-2pm
Sexual Health clinic and reception access		
Saturday	9am-1pm	
Both pre-bookable and daily on day appointments were offered to patients.		
Patients could book appointment up to four weeks in advance for all clinicians. On the day appointments were also available.		
The practice patients could access hub (group of sites in the community where all patients can access primary care) appointments in the community until 8pm Monday to Friday and between 8am and 8pm on Saturdays, Sundays and Bank holidays. These appointments were made by the practice or the NHS 111 service.		



## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4899	392	104	26.5%	2.12%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	98.4%	92.8%	94.8%	No statistical variation

## Older people

## Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>• All patients had a named GP who supported them in whatever setting they lived.</li> <li>• The practice was responsive to the needs of older patients. For example, Longer appointments were available for those with enhanced needs and complex medical issues.</li> <li>• The practice offered home visits and were currently involved in developing a nurse practitioner led home visit service with local neighbouring practices.</li> </ul>

## People with long-term conditions

## Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>• Patients with multiple conditions had their needs reviewed in one appointment.</li> <li>• The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.</li> <li>• Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.</li> <li>• Phlebotomy (blood tests) and health checks were offered four days a week and appointments were available at both sites to ensure equitable access.</li> <li>• The practice also offered extended hours appointments with the practice nurses, health care assistant and nurse practitioners as well as GPs.</li> </ul>

## Families, children and young people

Population group rating: Good

### Findings

- Additional nurse appointments were available until 7.15pm on Mondays and Tuesdays for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- Patients could access a GP and nurse appointment on the same day for the eight-week baby check and vaccinations.
- Children could access a same day appointment.
- Young people had access to contraception and/or sexual health testing (depending upon age and therefore in considering both Gillick competencies and Fraser Guidelines).
- The practice had annual accreditation for the 'You're Welcome' scheme since 2008. This provided a set of quality standards which practices must achieve to prove they are young people 'friendly'.

## Working age people (including those recently retired and students)

Population group rating: Good

### Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 8pm on a Monday and Tuesdays. Pre-bookable appointments were available to all patients at either the main practice or the branch.
- The practice patients could access hub appointments in the community until 8pm Monday to Friday and between 8am and 8pm on Saturdays, Sundays and Bank holidays. These appointments were made by the practice or the NHS 111 service.

**People whose circumstances make them vulnerable Population group rating: Good**

Findings
<ul style="list-style-type: none"> <li>• The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.</li> <li>• People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.</li> <li>• The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.</li> <li>• The practice offered longer appointments for those patients who needed additional time and those with a learning disability.</li> </ul>

**People experiencing poor mental health (including people with dementia) Population group rating: Good**

Findings
<ul style="list-style-type: none"> <li>• Priority appointments were allocated when necessary to those experiencing poor mental health.</li> <li>• Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.</li> <li>• The practice was aware of support groups within the area and signposted their patients to these accordingly.</li> </ul>

**Timely access to the service**

**People were able to access care and treatment in a timely way.**

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	73.5%	68.4%	70.3%	N/A
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	63.3%	66.0%	68.6%	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 (01/01/2018 to 31/03/2018)	56.5%	63.0%	65.9%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	57.2%	66.7%	74.4%	No statistical variation

Source	Feedback
For example, NHS Choices	<p>We reviewed the NHS website at the time of inspection. There were seven reviews. These were mixed and gave an overall score of 2 stars out of five. Negative comments included attitude of staff and access to appointments. Positive comments included feedback about the care and treatment received.</p> <p>The provider told us they had contacted NHS choices on several occasions to enable them to respond to some of the comments. The provider thought that the comments related to another practice that they previously shared a premises with.</p>

## 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.	8
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes

There was evidence that complaints were used to drive and monitor continuous improvement.	Yes
<p>Complaints regarding external stakeholders were reported using local mechanisms and also shared with agencies including NHS England and the local CCG.</p> <p>A complaint regarding unawareness of services provided by the practice had resulted in a review of how information was shared. For example, notice boards containing focussed information were introduced and the website reviewed to ensure up to date information was shared. The practice manager explained that following the building work the TV screens were due to be updated to include information about the practice.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient was unhappy about the way a staff member spoke with them during a consultation.	This was investigated by the practice. A letter of apology was sent to the patient and staff member (locum) was spoken to.
A newly registered patient at the practice was not happy about not being prescribed a medicine for a long-term condition. GPs said they had not received sufficient information from the patients previous GP.	Staff initially attempted to get the past medical history and dosage details from previous GP prior to administering the medicine. The patient went elsewhere to access the medicine. The patient remained unhappy with the response from the practice and contacted NHS England who then managed the complaint. No further action from the practice was required. The practice responded to the patient verbally and in writing to explain the reasons for the actions taken.

## Well-led

## Rating: Requires improvement.

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels. Leaders demonstrated 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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme in place, including a succession plan.	Yes
<p>Leaders were knowledgeable about issues and priorities relating to the quality and future of services and participated in external groups to ensure they understood the local changes and challenges. The leadership team proactively planned for the future organisation of the practice and prioritised work patterns and systems. They understood the challenges, had reported any concerns to external organisations and were addressing them. For example, by working with other practices within the area (Syndicate).</p>	

Staff said the GPs and leadership team were visible and approachable and added that communication was good.

## Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy in place to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: The strategy was in line with health and social care priorities across the local area. For example, the practice had recently accepted new patients following the closure of two nearby practices. The practice were working with local GP practices within the syndicate and community organisations (hubs) to offer patients additional services including minor surgery, extended hours and sexual health services.	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
Explanation of any answers and additional evidence: Staff said the practice was a good and supportive place to work. Patient feedback during this inspection confirmed staff were supportive, caring and professional.	
There were processes for providing all staff with the development they need. This included appraisal and career development conversations. We were told of examples where staff had been supported to develop their roles. For example, completing non-medical prescribing courses. All staff received annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.	

Staff said that because the practice was quite small communication was effective and usually informal. Staff appreciated the weekly clinical meetings, although a small number of staff said they were not always able to attend.

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

Source	Feedback
12 staff questionnaires and speaking with four members of staff.	All 12 questionnaires contained positive comments about working at the practice. Staff said that although the workload was 'heavy', 'hectic' and 'challenging' they 'enjoyed' working at the practice and 'got along with each other well'. Staff said the 'work environment had improved since the refurbishment' and added that the 'clinicians and management team were caring and approachable'.

## Governance arrangements

**The governance responsibilities, roles and systems did not support good governance and management.**

	Y/N/Partial
There were governance structures and systems in place which were regularly reviewed.	No
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Some governance arrangements were well established at the practice whilst others had been identified as requiring improvement. For example: <ul style="list-style-type: none"> <li>• Infection control audits and fridge temperature monitoring were completed by nursing staff. These were detailed and any actions were acted upon promptly.</li> <li>• Risk assessments for fire, health and safety, waste management and cleaning systems were maintained.</li> <li>• GPs monitored the clinical performance at the practice at the weekly clinical coffee mornings.</li> </ul> However, other systems were not established, monitored or effective. For example, <ul style="list-style-type: none"> <li>• The nursing team were responsible for the maintenance of emergency equipment in the practice. Checklists were maintained and monitored to highlight when medicine or equipment expiry dates were approaching. However, we found four items of emergency equipment that had exceeded expiry dates.</li> <li>• Recruitment records and checks were incomplete. Monitoring checks regarding professional nursing registration were not in place.</li> <li>• Not all practice policies had been reviewed in the last year. For example, although new contact details for safeguarding teams had been distributed to staff the safeguarding policy had not been reviewed since 2017.</li> <li>• Records to demonstrate that medicine re authorisation had taken place were not located on the patient record.</li> </ul>	



- Records and minutes of meetings relating to complaint and significant events did not reflect the actions and discussions described by staff.
- Systems were not in place to monitor two week wait referrals to ensure patients had received an appointment within the suggested timeframe, although this was immediately introduced.
- There was no overview of referrals and prescribing made by nurse practitioners at the practice.

## 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 in place which were regularly reviewed and improved.	Yes
There were processes in place to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: The programme of clinical and internal audit had been delayed due to recent organisational and environmental changes. We saw two complete cycle audits. One showed an improvement in quality of care, whilst another showed a deterioration. There were no documented actions to explain further actions to be taken following findings.	

## 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 adjust and improve performance.	Yes
Performance information was used to hold staff and management to account, although there was no clear or formally recorded oversight of locum staff or non-medical prescribers.	Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence: During checks of recruitment records some information missing responded in prompts to gather information. For example, NMC register checks for	

nurses and checks of previous employment.

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: Practice staff attended external stakeholder meetings to influence changes in the locality such as the Local Medical Council (LMC). The practice was part of a local syndicate of GP practices who met to offer support and join together to apply for additional funding and services.	

Feedback from Patient Participation Group (PPG).

Feedback
The practice no longer had an active face to face PPG. The practice had attempted to restart the group but had not had success. Therefore, they contacted patients by email to obtain feedback and had used external surveys to obtain views of the service provided. For example, the most recent survey was to gather the views on how aware patients were of the extended hours appointments and online services provided by the practice.

## Any additional evidence

Staff said feedback from patients and staff had helped to influence changes in the environment. The practice had previously shared frustrations regarding shared facilities and cramped conditions. The new premises had been completed in the Summer of 2018.

Patient feedback had also contributed to the change in the telephone system used at the practice. For example, the practice had used a 0844-telephone number but patients objected to this. The telephone number was changed to a local dialling code.

## Continuous improvement and innovation

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

	Y/N/Partial
There was a focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: Learning from recent significant events was shared with the CCG and NHS England.	

## Examples of continuous learning and improvement

The practice held a weekly clinical coffee morning where any clinical issues, changes in national guidelines, safety alerts, complaints and significant events were discussed informally.

The practice were part of a local group (syndicate) of GP practices. The group met each month to offer support, share resources and combine to apply for additional funding and services. The practice had offered other local practices back office support as part of this process.

The practice had a history of being a training practice and had been accredited last year by the Deanery. However, this had been put on hold because of the practice refurbishment. There was a plan to reintroduce this service in the near future.

### 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 Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	No statistical variation	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

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.

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>

### Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **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.