Care Quality Commission

Inspection Evidence Table

Cauldwell Medical Centre (1-4111164292)

Inspection date: 6 March 2018

Date of data download: 06 March 2019

Overall rating: Good

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

Safe Rating: Good

At the February 2018 inspection we rated the practice as requires improvement for providing safe care. We found that:

- **There was a lack of learning when things went wrong. There was a lack of practice meetings and lessons learnt from significant events and complaints were not shared on a formal basis.**
- **The practice had not formally assessed the risk of not holding specific paediatric emergency equipment.**
- **The system for reviewing repeat medicines or medicines requiring additional monitoring was not effective.**

At the March 2019 inspection we found that:

- **The practice held regular meetings with all practice staff where significant events and complaints were shared. The practice also shared learning from the wider organisation.**
- **The practice held all paediatric equipment and had formally assessed any emergency medicines not held.**
- **The system to review medicines had been reviewed and was safe.**

These improvements have resulted in the change of rating.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: The practice policies for safeguarding adults and children included all relevant local escalation details. All staff were trained in safeguarding appropriate to their role. Safeguarding was a standing agenda item at monthly clinical governance meetings and six-weekly multidisciplinary (MDT) meetings. The practice was able to describe how they worked with local agencies to ensure coordinated care for patients that may be vulnerable. The practice had embedded templates into the computer system to highlight patients on safeguarding register and ensure clinical records were up-to-date.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and	Y

pharmacists) was checked and regularly monitored.	
Staff had any necessary medical indemnity insurance.	Y

Explanation of any answers and additional evidence:

The recruitment of staff was managed by the Virgin Care human resources team. The practice was able to provide evidence that appropriate recruitment checks were carried out, including DBS checks.

A full record of staff immunisations was held. The practice had run staff clinics to ensure blood tests were completed and vaccinations offered where appropriate.

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: November 2018	Y
There was a record of equipment calibration. Date of last calibration: August 2018	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: January 2019	Y
There was a log of fire drills. Date of last drill: July 2018	Partial
There was a record of fire alarm checks. Date of last check: February 2019	Y
There was a record of fire training for staff. Date of last training: Ongoing as required by staff	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: January 2019	Y
Actions from fire risk assessment were identified and completed.	Y

Explanation of any answers and additional evidence:

The maintenance of the premises used by the practice was carried out by Bedford Hospital estates team.

We saw evidence that the fire extinguishers were checked every two weeks.

Due to the recent relocation of the practice, a recent fire drill had not been completed however, the service was evacuated in July 2018 due to the fire alarm being activated. There was a fire drill planned for May 2019. Due to the high level of patients and services that are at Bedford Hospital, fire drills are organised by central teams to involve minimal disruption to services.

We saw evidence that the fire alarms were tested weekly.

A fire risk assessment had been completed in January 2019, following the relocation of the service. We saw that an action plan had been developed with timescales for completion of any remedial action. For example, we saw that electrical testing had been identified as needing completion and this had been booked for May 2019.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y

Date of last assessment: January 2019	
Explanation of any answers and additional evidence: We saw that a security risk assessment had been completed in November 2017. There had not been a repeat assessment since the service relocated. The practice had plans to complete this assessment.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit:	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: Staff were aware of their responsibilities for infection prevention and control. We saw that the premises were visibly clean and tidy and records were kept of cleaning that was carried out. We saw that sharps boxes were appropriately labelled however, these were kept on a low level where young patients may be able to reach. The practice told us they would resolve this immediately.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

Explanation of any answers and additional evidence:

The practice had ensured that all reception staff were knowledgeable in the ‘red flag’ symptoms of sepsis by providing online training and discussion at practice meetings. Staff told us that these patients were escalated for clinician review quickly. As the practice was on a hospital site, staff they told us that if acutely unwell patients accessed the service the hospital would support with emergency care as necessary.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
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.	Y
Explanation of any answers and additional evidence: We saw evidence that correspondence into the practice was managed within 24 hours. Pathology results were allocated to clinicians on the day they arrived at the practice. The practice management team monitored these systems throughout the day to ensure there was no backlog.	

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)	0.76	1.00	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)	6.6%	8.2%	8.7%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2018 to 30/09/2018) (NHSBSA)	5.26	6.02	5.64	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2018 to 30/09/2018) (NHSBSA)	1.89	2.33	2.22	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about	Y

Medicines management	Y/N/Partial
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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:

Blank prescriptions were managed safely and logged into each clinical room for the duration of the clinical session. Once the session had finished, all blank prescriptions were removed from the room and stored securely.

The practice completed regular audits of patients that were on repeat medicines to ensure they had received a full medicine review in the previous 12 months.

We saw evidence of a thorough system of peer review for non-medical prescribers to ensure appropriate prescribing. This was completed on a six-monthly basis.

Medicines that required additional monitoring were managed by the GP and the practice pharmacist. The system had been reviewed and we saw that this had improved safety. We looked at clinical records and found that all patients had received appropriate monitoring prior to a prescription being provided.

The practice monitored the use of antibiotics and had audited prescribing of these medicines to ensure they were used appropriately.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	38
Number of events that required action:	38
Explanation of any answers and additional evidence: We saw evidence that significant events were logged, actions completed and learning taken from them. Significant events were discussed and shared with staff at all clinical governance meetings. Staff told us they were comfortable raising concerns with the practice management team and understood how to access and complete incident forms. We saw evidence that significant events were shared with the wider organisation of Virgin Care and that learning was shared between all practices in the organisation.	

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

Event	Specific action taken
A medicine that required additional monitoring was prescribed without having an up-to-date blood test result.	The system for prescribing medicines that required additional monitoring was reviewed. Administration staff downloaded all blood results from the hospital system and flagged any patients that did not have recent results. Patients were contacted to arrange blood tests where necessary. We saw evidence of this being discussed at clinical governance meetings where staff were reminded not to prescribe without adequate monitoring.
There was a six-week delay between a repeat prescription request and the prescription being issued.	It was seen that there was a lack of clinical administration time for clinicians. A business case was put forward to the organisation to review staffing levels and clinicians were provided with higher levels of administration time.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	

The lead GP held a log of all safety alerts and actions taken. We saw evidence that they were discussed at clinical governance meetings. Records we checked showed that safety alerts had been acted on appropriately.

Effective Improvement Rating: Requires

At the February 2018 inspection we rated the practice as requires improvement for providing effective care. We found that:

- **The practice did not hold regular multi-disciplinary team (MDT) meetings with community teams to share information and coordinate care.**
- **Quality Outcome Framework (QOF) data for 2016/17 was not available for the practice due to the merger of three practices and the new provider taking over in August 2017. QOF is the annual reward and incentive programme detailing GP practice achievement results. QOF is a voluntary process for all practices in England and was introduced as part of the GP contract in 2004.**
- **There was a lack of quality improvement processes, such as audit. The practice was not able to evidence quality improvement strategies.**

At the March 2019 inspection we found that:

- **The regularly held MDT meetings to coordinate care for vulnerable patients.**
- **QOF indicators for patients suffering for conditions such as diabetes, asthma and hypertension were below national and local averages. We saw unverified data to indicate that these indicators had improved in the last twelve months, however, these results had not been submitted or published.**
- **The practice uptake for child immunisations was below local and national averages.**
- **The practice uptake for national cancer screening programmes was below local and national averages.**

The ratings have not been changed since the February 2018 inspection.

Effective needs assessment, care and treatment

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

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

There were appropriate referral pathways were in place to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
Explanation of any answers and additional evidence: Guidance from the National Institute of Clinical Excellence (NICE) was discussed at clinical governance meetings and necessary actions taken. Clinical records we looked at confirmed this.	

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)	0.69	0.91	0.81	No statistical variation

Older people — Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The 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.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- The practice was aware of the low performance indicators with regard to patients with long-term conditions. We saw unverified data that indicators were improving in these areas. The practice had plans to further improve on diabetes management through weekly care planning sessions between the diabetes lead nurse and the GP.
- Due to the merger of three practices, not all patients were entered onto the correct registers for long-term conditions and reviews were not adequately documented. The practice was working to improve the coding of these patients.
- 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. The practice ensured all patients with an asthma diagnosis were offered personalised care plans.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

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)	55.5%	79.1%	78.8%	Significant Variation (negative)
Exception rate (number of exceptions).	11.7% (55)	15.8%	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)	50.0%	75.8%	77.7%	Significant Variation (negative)
Exception rate (number of exceptions).	8.3% (39)	13.7%	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)	67.2%	82.1%	80.1%	Variation (negative)
Exception rate (number of exceptions).	6.8% (32)	15.6%	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)	59.9%	76.6%	76.0%	Variation (negative)
Exception rate (number of exceptions).	3.7% (17)	8.0%	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)	68.8%	90.1%	89.7%	Variation (negative)
Exception rate (number of exceptions).	3.0% (2)	13.8%	11.5%	N/A

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)	61.9%	82.1%	82.6%	Significant Variation (negative)
Exception rate (number of exceptions).	4.0% (31)	5.1%	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)	97.7%	92.5%	90.0%	No statistical variation
Exception rate (number of exceptions).	4.4% (2)	5.0%	6.7%	N/A

Families, children and young people

Population group rating: Requires Improvement

Findings

- Childhood immunisation uptake rates were below with the World Health Organisation (WHO) targets.
- The practice had identified that their practice population could be transient and therefore it was difficult to engage with these patients. They had been proactive in working the community midwives and health visitors to improve the uptake of these immunisations.
- The practice contacted new mothers directly to book appointments and carried out all new baby checks and immunisations at one appointment.
- 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 could access services for sexual health and contraception.

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)	133	147	90.5%	Met 90% minimum (no variation)
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)	100	121	82.6%	Below 90% minimum (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)	100	121	82.6%	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)	102	121	84.3%	Below 90% minimum (variation negative)

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. • The practice had not offered NHS healthchecks in 2018/19 due to a lack of clinical space at their previous location however, had plans to reintroduce this service now they had room to do so. • Patients who had received reviews, investigations, blood tests or referrals were routinely followed up. • Patients could order repeat medicines, book or cancel appointments online without the need to attend the surgery.

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) (01/04/2017 to 31/03/2018) (Public Health England)	54.2%	74.0%	71.7%	Variation (negative)
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	55.9%	73.2%	70.0%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	32.5%	56.3%	54.5%	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. (01/04/2017 to 31/03/2018) (PHE)	55.6%	61.1%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	71.4%	55.7%	51.9%	No statistical variation

Any additional evidence or comments
The practice was aware of the lower than average uptake of cervical screening programme. They had identified that there may be a cultural barrier for patients using this service. The practice ensured they had good access to interpreting services for patients that did not have English as a first language and had posters in the waiting room to encourage uptake.

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 met regularly with community teams and worked closely with district and palliative care nurses. • The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. • The practice ensured that patients with no fixed abode were able to register at the practice and would use the practice address to ensure that referrals could be made where necessary. • 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 lead GP was a specialist for substance abuse and patients were referred to support services where

necessary.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

- The practice was aware of the lower than average clinical indicators in this area. We saw unverified data that showed this had improved with 53 out of 80 mental health reviews being completed in the last 12 months.
- The practice had a link to the community psychiatric nurse who could provide on-site assessments where necessary.
- 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 medication.
- 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. These patients were followed up by the practice as necessary.
- The practice had provided reviews for all patients on their dementia register in the last 12 months.
- All staff had received dementia training in the last twelve months.

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)	60.6%	90.1%	89.5%	Significant Variation (negative)
Exception rate (number of exceptions).	10.1% (8)	20.0%	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)	44.0%	91.3%	90.0%	Significant Variation (negative)
Exception rate (number of exceptions).	5.1% (4)	17.0%	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)	63.6%	84.1%	83.0%	No statistical variation
Exception rate (number of exceptions).	8.3% (2)	8.3%	6.6%	N/A

Any additional evidence or comments
The practice was aware of the low indicators in this area. We saw unverified data that the practice had improved in these areas. The practice continued to work on ensuring that diagnosis and reviews were appropriately entered on their clinical computer system.

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 however, clinical indicators were below national and local averages.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	404.9	538.5	537.5
Overall QOF exception reporting (all domains)	7.1%	6.3%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used	Partial

information about care and treatment to make improvements.	
Explanation of any answers and additional evidence: The practice was involved in quality improvement strategies such as audit however, QOF indicators for patients suffering from various conditions, such as diabetes and hypertension, were below local and national averages. The practice was aware of these low indicators and we saw unverified data that this had improved over the last twelve months since these figures were published.	

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

- Repeated audits on medicines that required additional monitoring had improved practice in this area. This highlighted that not all patients were having the relevant blood tests prior to prescribing and therefore the system was reviewed. Repeat audits had been completed that indicated that the new system where administrative staff downloaded results from the hospital system was providing safer prescribing.
- An audit had been completed regarding patients who were diagnosed with gestational diabetes. These patients had been added to the recall system to ensure they had regular reviews.
- Audits had been completed for the review of patients with a diagnosis of depression. The practice ensured that depression assessment tools were embedded within patient records and scheduled reminders to book reviews.

Effective staffing

The practice was able 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.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: All staff had access to online training and had received all necessary mandatory training. Some staff told us that they would value additional training as their sphere of competence had increased and this had been discussed in appraisals. The practice did not use the Care Certificate for Health Care Assistants however, the induction programme included all the skills that were included in this framework.	

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)	Y
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.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or	Y

organisations were involved.	
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence: The practice held regular meeting with community services to ensure coordinated care. These meetings included discussion for patients that were on palliative and safeguarding registers.	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence: Reception staff had received training in signposting and care navigation and the practice had begun to use this when patients contacted the surgery. Self-care information was available in the waiting area.	

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)	88.8%	94.9%	95.1%	Variation (negative)
Exception rate (number of exceptions).	0.5% (7)	1.0%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Explanation of any answers and additional evidence: Clinical staff had received training in the mental capacity act and had good knowledge of Gillick competence and Fraser guidelines. Gillick competence is concerned with determining a child's capacity to consent. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment	

Caring Rating: Good

The practice was rated good for providing caring services in the February 2018 inspection.

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: Patients told us that staff were compassionate and caring towards them.	

CQC comments cards	
Total comments cards received.	42
Number of CQC comments received which were positive about the service.	27
Number of comments cards received which were mixed about the service.	8
Number of CQC comments received which were negative about the service.	7

Source	Feedback
CQC comment cards	Patients reported that they felt they received good care and treatment from the staff. They told us that they felt listened to and treatment was explained to them in a way they could understand. Negative comments included difficulty in obtaining an appointment and that the shared waiting room (shared with the urgent care clinic at Bedford hospital) could be noisy and crowded.
Patient interviews	Patients we spoke with told us that they were happy with the service provided by the clinical staff and that reception staff were friendly and helpful. Some patients told us there could be difficulty in making an appointment and there was not a female GP available on every day of the week.

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
8779	406	89	21.9%	1.01%

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)	76.5%	88.7%	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)	73.7%	85.7%	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)	84.3%	95.7%	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)	70.6%	82.0%	83.8%	No statistical variation

Any additional evidence or comments
Prior to the relocation of the service in January 2019, there was not enough clinical rooms to accommodate all the clinical staff and the practice was aware that this had a negative effect on access. The practice were hopeful that the new premises would alleviate this problem.

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

Any additional evidence
The practice had a suggestion box in the waiting area and monitored NHS Friends and Family results. The practice had completed a patient feedback survey and planned to repeat this in May 2019. The main issues raised in the patient survey were around the suitability of the premises and parking charges at the site. The practice were working with Bedford Hospital to try to reduce the parking charges for patients at the practice. The practice promoted the use of the suggestion box by using a 'You said, we did' board that included details of the changes made following patient suggestions, such as increased signage and more organised notice boards.

Involvement in decisions about care and treatment

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

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

Source	Feedback
Interviews with patients.	Patients we spoke with told us that they felt that staff had time to listen to them and involved them in their care.
CQC comment cards	Most comment cards were positive about the care given by the practice staff. Patients reported situations where the clinical staff had been caring and empathetic. A small number of CQC comment cards referred to feeling rushed in appointments.

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)	84.8%	92.7%	93.5%	No statistical variation

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

Explanation of any answers and additional evidence:

The practice had identified that a large number of their practice population did not speak English as a first language. The practice regularly used interpreting services. Registration forms asked if interpreters were needed and this was highlighted on the patient records to ensure that interpretation services were booked in advance where possible. Appointments where interpreters were needed were extended to twenty minutes.

We saw evidence of reception staff assisting with the registration of patients that did not speak English.

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 110 carers, which was 1.1% of their practice population.
How the practice supported carers.	The practice had a carers noticeboard in the waiting area to signpost carers to relevant support services. They also gave carers information packs and directed them to the Virgin Care carers website which had resources and information available. The practice worked with the carers lounge in Bedford Hospital and were able to refer to this service. The carers lounge staff visited the practice and held stalls in the waiting areas to proactively identify carers.
How the practice supported recently bereaved patients.	The practice sent bereavement letters to families that included information for local support networks.

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.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive Rating: Good

The practice was rated as Good for providing responsive services at the February 2018 inspection.

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.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
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.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
8779	406	89	21.9%	1.01%

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)	82.9%	94.1%	94.8%	No statistical variation

Any additional evidence or comments

The practice had increased the team of nursing staff and employed practice pharmacists to improve access and give patients flexibility of appointments. The practice was also hopeful that the new premises and increased space would also help with access to appointments.

Older people — Population group rating: Good

Findings

- All 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.

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

Findings

- Patients with multiple conditions currently were unable to have their needs reviewed in one appointment due to the specialties of different nurses. The practice was working on the creating of combination clinics where multiple conditions could be reviewed at one time.
- 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.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people — Population group rating: Good

Findings

- Nurse appointments were available until 6.30pm Monday to Friday 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.
- All parents or guardians calling with concerns about a child were offered a same day appointment. The practice had emergency appointments that were blocked for children under twelve years old.
- Community midwife teams held weekly clinics at the practice.

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 part of an extended access programme where appointments were available from 6.30pm to 8pm Monday to Friday and Saturday and Sunday mornings.
- The practice offered an online system where patients were able to book and cancel appointments without having to telephone the practice.

People whose circumstances make them vulnerable

Population group rating: Good

Findings
• 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. • The practice adjusted the delivery of its services to meet the needs of patients with a learning disability for example, longer appointments

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings
• Priority appointments were allocated when necessary to those experiencing poor mental health. • Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. • The practice was aware of support groups within the area and signposted their patients to these accordingly. • The practice was able to book appointments directly with the community psychiatric nurse who held clinics at the practice.

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.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence: The reception team had a 'red flag' list of symptoms to prompt them to escalate urgent patients for clinician reviews. Patients who requested home visits were telephoned by the GP to triage and home visits are conducted as necessary.	

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)	69.5%	N/A	70.3%	No statistical variation
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)	61.6%	66.2%	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)	51.8%	61.4%	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)	62.5%	71.7%	74.4%	No statistical variation

Source	Feedback
CQC comment cards	CQC comment cards we received were mixed with regard to access to appointments. Some comment cards told us that they found it difficult to access the service by telephone to make an appointment. Some comment cards

	described situations where reception staff had been very helpful with making appointments at short notice.

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.	13
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: Complaints were discussed at each clinical governance meeting. Discussion included learning and improvements.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Several complaints were received from patients regarding the telephone signal dropping while they were on a call.	The practice investigated the telephone line and discovered that the signal was dropping on a frequent basis. They changed the telephone system supplier and have monitored the line to ensure this does not continue.
A patient had not had treatment fully explained and was not aware that a referral for further investigation had been made.	The practice sent a written apology to the patient. The complaint was discussed at a clinical governance meeting where all clinicians were reminded to ensure patients had full understanding of treatment plans.

Well-led Rating: Good

The practice was rated as requires improvement at the February 2018 inspection. We found that:

- **There was a lack of clinical governance to ensure safe and effective care.**
- **There was a lack of formal supervision and appraisal for clinical staff.**
- **There was limited protected time for staff to complete training.**

At the March 2019 inspection we found:

- **The practice held regular clinical governance meetings and the leadership was aware of the challenges to the practice.**
- **There was an effective system for formal supervision and appraisal for clinical staff, including audits for no-medical prescribers.**
- **Staff had time to complete mandatory training and staff had completed the necessary training.**

These improvements have led to a change of rating.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: The practice was aware of the challenges that faced them and the needs of the practice population. Staff reported that management teams were approachable and responsive to comments and concerns.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y

Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: The practice mission statement included high quality patient care that was safe, ethical, passionate and timely. Staff were aware of these core values and worked towards them in their practice. The practice understood where their challenges were, such as improving levels of reviews for long-term conditions and were working towards these objectives.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y

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

Source	Feedback
Staff Interviews	Staff told us they enjoyed working at the practice and felt proud to be part of the team. The administration staff worked in a different area and told us that it could be isolating at times but they could always access support where needed. The practice had plans to extend their current premises to ensure all the team worked in the same area.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: The practice had a system of organisational and clinical audits. We saw evidence that this drove service improvements. QOF indicators were often lower than national and local averages however, we saw unverified data that indicators had improved in the last twelve months. The practice had a comprehensive programme of risk assessment however, a security risk assessment since the practice had relocated had not been undertaken.	

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.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: The practice regularly reviewed patient feedback and used this to improve services. There was a 'You said, we did' board to communicate this to the patient population. For example, comments from patients had been received asking for self-care and health information on the display screens in the waiting area and this had been actioned. Staff feedback was gained at whole practice meetings which were held quarterly.	

Feedback from Patient Participation Group.

Feedback
The practice did not have an active patient participation group (PPG). The practice told us they had sent letters to a large number of their practice population and only received two responses. The practice told us they planned to build a virtual PPG.

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.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: We saw evidence of a continuous cycle of development and service improvement. This included learning from significant events and complaints, responding to safety alerts and guidance and clinical audit cycles.	

Examples of continuous learning and improvement
• The process for safe prescription of medicines, including those that need additional monitoring, had been improved and we saw evidence that all medicines were prescribed safely. • All safety alerts were discussed at clinical governance meetings and actions taken. We looked at three safety alerts and they had all been actioned appropriately. • Complaints and significant events were reviewed at each clinical governance meeting. We saw

that these improved systems. For example, an incident involving the delay of a referral had led to a daily check of correspondence being completed by administration staff.

- The practice used regular peer review to improve practice and ensure competence of staff. Each clinician had six sets of clinical notes reviewed by the lead GP on a six-monthly basis. These reviews included prescribing information, explanations given to patients and record keeping. These were then shared with the staff member and themes were analysed for discussion at clinical governance meetings. An external company completed additional peer reviews on a yearly basis that included the lead GP and learning was shared where appropriate.

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.
- 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.

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.