

# Care Quality Commission

## Inspection Evidence Table

### Littletown Family Medical Practice (1-542588138)

Inspection date: 12 February 2019

Date of data download: 31 January 2019

**Overall rating: Inadequate**

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

**Safe Rating: Inadequate**

#### Safety systems and processes

**The practice did not have 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.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding.	Yes
Policies and procedures were monitored, reviewed and updated.	Partial
Policies were accessible to all staff.	Yes
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
There were systems 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.	Partial
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: The safeguarding policy had been reviewed in January 2019. This stated that the practice would arrange an annual training session that all clinical and non-clinical staff were expected to attend. We were told	

Safeguarding	Y/N/Partial
that this did not occur. However, on-line training took place approximately every three years and we saw all staff had received training.	
We saw examples of staff displaying a good understanding of safeguarding procedures and taking appropriate action when issues were identified.	
Evidence of a DBS check being received for all clinicians was not available during the inspection. The practice manager told us DBS checks were requested but they were issued to the clinician's home address so the practice did not have sight of them.	
Following the inspection the practice provided evidence that they had received a DBS check for the practice nurse but it had not been in the personnel file at the time of the inspection. They provided evidence that a DBS check for the salaried GP had been applied for and paid for, but a DBS certificate or disclosure number was not supplied.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	No
Staff had any necessary medical indemnity insurance.	Partial
Explanation of any answers and additional evidence:	
The recruitment policy did not give guidance about checking qualifications, professional registration, or who should have a DBS check. The policy stated that a firm and unconditional offer of employment was made following the receipt of satisfactory references and medical information. The practice manager told us the policy needed updating. The policy was undated.	
There was no system to regularly check the registration of clinical staff.	
A practice nurse had resigned from their position in May 2016. They were now a self-employed care coordinator/community nurse at the practice working once a week. Their personnel file contained some training information but there was nothing to suggest they were currently working at the practice.	
The practice manager told us they paid for medical indemnity insurance for all clinicians. However, they did not keep evidence of this; they said the certificates went to the home addresses of the clinicians.	
The practice manager told us they did not have a system for keeping information on locum GPs. They were able to locate relevant information for current locum GPs but said they had disposed of some electronic information for other locum GPs as a lot had been held.	

<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: 06/02/2019	Yes
There was a record of equipment calibration. Date of last calibration: 30/01/2019	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: August 2018	Yes
There was a log of fire drills. Date of last drill: 12/07/2018	Yes
There was a record of fire alarm checks. Date of last check: 06/02/2019	Yes
There was a record of fire training for staff. Date of last training: Various Dates for on-line training	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 16/02/2010	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>A fire risk assessment checklist had been completed on 16/02/2010. This included general questions such as about the wiring of electrical installation being inspected periodically, portable electric equipment being regularly inspected, staff being aware of hazards and emergency procedures and fire exit doors being clear and unobstructed. It had not been repeated since 2010.</p> <p>There was one trained fire warden. There was no protocol to follow if the fire warden was not in work.</p> <p>There was a fire policy but this had not been personalised to the practice. Some information in it did not relate to the practice. We were told it had been in place since August 2017 and it had been downloaded from a website.</p>	

<b>Health and safety</b>	<b>Y/N/Partial</b>
Premises/security risk assessment had been carried out. Date of last assessment: 15/02/2017	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 15/02/2017	Yes

## Infection prevention and control

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

	Y/N/Partial
There was an infection control policy.	Yes
Staff had received effective training on infection prevention and control.	Partial
Date of last infection prevention and control audit: 30/01/2019	Yes
The practice had acted on any issues identified in infection prevention and control audits.	No
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had carried out its only infection control audit on 30/01/2019. They had scored 87% and the audit results were noted that it would be repeated monthly until they scored a green rating. During the inspection the practice manager stated this was incorrect and it would be repeated quarterly. There was no detail about how the required improvements would be made.</p> <p>The infection control policy stated there would be annual infection control and handwashing training. We saw that not all staff had received infection control training, and training was not provided annually. We saw evidence that a handwashing audit had been carried out in January 2019.</p> <p>In one of the clinical rooms a sharps box was noted as being opened 19/05/2017. Not all sharps boxes were wall mounted.</p> <p>We found three out of date forceps. We were told that these had been used when the nurse removed coils, but they no longer carried out this practice. The practice leaflet still included information about the practice nurse carrying this out.</p>	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	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	Yes

other clinical emergency.	
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Yes

### 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.	Yes
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

### Appropriate and safe use of medicines

#### The practice did not all the required have 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) <small>NHS Business Service Authority - NHSBSA)</small>	1.05	1.22	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) <small>(NHSBSA)</small>	4.7%	8.7%	8.7%	Variation (positive)

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 guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
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
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
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 to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	No
<p>Explanation of any answers and additional evidence:</p> <p>Fridge temperature checks were carried out but only the actual temperature was recorded, not the minimum and maximum. The practice had a data logger but the temperatures were set to a minimum of 2°C and 12°C, and not the required 8°C maximum. We saw instances of the maximum temperature being 8.5°C but this had not been actioned due to the incorrect temperature being set. There was no protocol for the action to take if the temperature was outside the required range.</p>	

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

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	No
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	No
Number of events recorded in last 12 months:	Unclear
Number of events that required action:	Unclear
Explanation of any answers and additional evidence:	
There was a system to record and act on significant events, but this was not effective. Staff recorded incidents on a form and then the practice manager decided if it would be treated as a significant event or a complaint.	
We were provided with a list of significant events for 2018. This gave brief information of 57 significant events. We saw that some of these were accidents and complaints, and some had been duplicated.	
We examined the significant event folder for 2019. This contained 11 significant events and of these we found eight had not been handled effectively. For example, discussions and actions were not documented and no review dates had been set to assess if significant events had been repeated.	
The significant event folder did not contain details of all these significant events. We found they were not fully documented and there was little information about investigations or learning points. Significant events were not reviewed.	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
9 January 2019. Medicines added to the incorrect patient record - similar EMIS numbers.	The records were amended. There was no record of any apology being given or further action or learning. There was no review date.
17 January 2019. Incorrect medicine dose prescribed.	An apology was given to the patient. Actions were "Need to concentrate more". There was no record of a discussion and no review date.
25 January 2019. Child under 5 not seen as arrived late. Parents called NHS111 and they were referred back to surgery.	The patient was referred back to the practice as the child was under five and as part of the GP contract should be assessed on the day. The patient was seen by a GP later the same day. Actions recorded on the form were "GPs assess under 5s before turning away". There was no review date.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Safety alerts were sent to the practice manager who forwarded them to relevant staff. We saw action that MHRA alerts had been actioned. Alerts were not actioned when the practice manager was off work.</p> <p>Alerts were not discussed in practice meetings. NICE guidance was mentioned to clinicians but we were told it was not discussed with administrative staff as it was too clinical.</p> <p>All alerts and guidance were kept in a shared drive accessible to all staff.</p>	



## Effective

## Rating: Requires improvement

### 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.	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
There were 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

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) <small>(NHSBSA)</small>	1.15	1.25	0.81	No statistical variation

## Older people

## Population group rating: Requires improvement

Findings
<p>Although we saw good practice in this area the effective domain was rated as requires improvement overall due to a breach of regulation 18 (staffing). This impacted on all population groups.</p> <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>• Health checks were offered to patients over 75 years of age.</li> <li>• The practice had purchased a machine to help diagnose atrial fibrillation in patients over the age of 65.</li> </ul>

## People with long-term conditions

## Population group rating: Requires improvement

### Findings

Although we saw good practice in this area the effective domain was rated as requires improvement overall due to a breach of regulation 18 (staffing). This impacted on all population groups.

- 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.
- 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 could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice had purchased a machine to diagnose atrial fibrillation.
- A machine had been purchased for earlier and easier diagnosis of asthma.
- In the previous year the practice had diagnosed 33 new diabetic patients from their Hba1c screening. They had also diagnosed 216 non-diabetic hypoglycaemia patients.
- Blood pressure monitoring machines were loaned out to patients for a week so a true reading could be obtained.

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) <small>(QOF)</small>	84.5%	75.3%	78.8%	No statistical variation
Exception rate (number of exceptions).	8.7% (35)	7.1%	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) <small>(QOF)</small>	88.4%	74.8%	77.7%	No statistical variation
Exception rate (number of exceptions).	7.9% (32)	5.9%	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) <small>(QOF)</small>	91.3%	79.6%	80.1%	Variation (positive)
Exception rate (number of exceptions).	8.4% (34)	9.2%	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) <small>(QOF)</small>	83.2%	76.6%	76.0%	No statistical variation
Exception rate (number of exceptions).	7.4% (23)	3.7%	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) <small>(QOF)</small>	91.8%	88.3%	89.7%	No statistical variation
Exception rate (number of exceptions).	0 (0)	6.9%	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)	88.9%	81.9%	82.6%	No statistical variation
Exception rate (number of exceptions).	1.1% (6)	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)	96.9%	92.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	0 (0)	4.1%	6.7%	N/A

## Families, children and young people

## Population group rating: Requires improvement

Findings
<p>Although we saw good practice in this area the effective domain was rated as requires improvement overall due to a breach of regulation 18 (staffing). This impacted on all population groups.</p> <ul style="list-style-type: none"> <li>• Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets.</li> <li>• 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.</li> <li>• 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. When a child did not attend a practice or hospital appointment their parents received a telephone call or letter.</li> <li>• Young people could access services for sexual health and contraception.</li> </ul>

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)	76	76	100.0%	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)	63	67	94.0%	Met 90% minimum (no variation)
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	67	92.5%	Met 90% minimum (no variation)
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)	65	67	97.0%	Met 95% WHO based target (significant variation positive)

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

### Population group rating: Requires improvement

#### Findings

Although we saw good practice in this area the effective domain was rated as requires improvement overall due to a breach of regulation 18 (staffing). This impacted on all population groups.

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice had recently employed a staff member with experience of working in a women's hospital. They were receiving updated training and would look at improving the cervical screening figures.

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)	70.8%	71.5%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	64.9%	66.6%	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)	50.5%	52.5%	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)	84.6%	71.8%	70.3%	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)	36.8%	51.5%	51.9%	No statistical variation

**People whose circumstances make them vulnerable**

**Population group rating: Requires improvement**

**Findings**

Although we saw good practice in this area the effective domain was rated as requires improvement overall due to a breach of regulation 18 (staffing). This impacted on all population groups.

- 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 such as 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 had flexible appointments so vulnerable patients could attend at times convenient to them.

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

**Population group rating: Requires improvement**

**Findings**

Although we saw good practice in this area the effective domain was rated as requires improvement overall due to a breach of regulation 18 (staffing). This impacted on all population groups.

- 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.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- 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.
- Dementia training had been provided for staff but this was approximately four years ago.
- The practice had identified that care planning for patients with dementia or mental health issues was low. They had met to discuss this and were increasing the nurse appointment time to 30 minutes so dementia checks could be carried out.

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)	91.2%	86.5%	89.5%	No statistical variation
Exception rate (number of exceptions).	22.7% (10)	9.1%	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)	91.7%	88.1%	90.0%	No statistical variation
Exception rate (number of exceptions).	18.2% (8)	6.0%	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)	87.5%	81.4%	83.0%	No statistical variation
Exception rate (number of exceptions).	0 (0)	4.8%	6.6%	N/A

## 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.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	559.0	531.6	537.5
Overall QOF exception reporting (all domains)	5.9%	4.8%	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

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

<p>We saw that the practice carried out clinical audits and salaried GPs were encouraged to carry them out. Some audits were not dated and some had not reached the date for a second audit to take place. However there was a system in place for audits to be repeated.</p> <p>Examples of audits completed are:</p> <ul style="list-style-type: none"> <li>We saw an undated audit of patients where a scan of patients with diabetes showed they had a fatty liver. In these cases there was a target for 100% of identified patients to have a fibrosis score and no patients were scored. This was discussed in a clinical meeting and the audit was to be repeated in 12 months.</li> <li>We saw an audit in April 2018 to ensure all lesions excised in minor surgery were sent for a histology report. All 17 identified cases had been sent for a report. It was noted to repeat the audit in 12 months.</li> </ul>
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## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Partial
The learning and development needs of staff were assessed.	No
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Partial
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.	No
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	No
<p>Explanation of any answers and additional evidence:</p> <p>Although we saw a blank induction document the practice manager told us they did not have a formal induction for new staff. They said as the practice was small they had informal inductions and knew when new staff were able to work in their role. The personnel files we examined did not contain information about induction.</p> <p>Some training took place during monthly practice meetings and staff had access to on-line training. We saw some gaps in staff training, for example in infection control, and saw that there had been an intense period of staff training in the two weeks prior to the inspection.</p> <p>Regular staff appraisals did not take place. We saw that some staff had completed a pre-appraisal form in 2018 but there was no evidence of an appraisal then taking place. The practice manager had never had an appraisal and had worked at the practice for over 10 years. Where kept, appraisal notes were brief and no individual targets had been set. The practice manager carried out the appraisals for the practice nurse and healthcare assistant with no clinical input.</p> <p>The practice manager told us they were looking at staff job descriptions as they thought some things were not being done.</p>	

## 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

## 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
Explanation of any answers and additional evidence: The practice took part in social prescribing in Oldham. It had a leaflet available to patients to explain the service. This included helping with issues such as social isolation, loss of confidence, accessing training or volunteering opportunities and healthy lifestyle choices.	

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) <small>(QOF)</small>	96.2%	95.5%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.2% (2)	0.4%	0.8%	N/A

### Consent to care and treatment

**The practice 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

## Caring

## Rating: Requires improvement

### Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

	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

### 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
4,330	420	99	23.57%	2.29%

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)	92.4%	87.0%	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)	81.8%	84.8%	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)	95.4%	93.9%	95.6%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
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)	80.3%	81.8%	83.8%	No statistical variation

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

Any additional evidence
The most recent in-house patient survey was carried out in March 2017. The action plan was to continue having a morning open surgery and have nurse appointments from 7.30am one day a week. They discussed early morning GP appointments but none of the GPs were able to facilitate this at the time.

### Involvement in decisions about care and treatment

**Staff usually 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
Explanation of any answers and additional evidence: There was some information displayed in the waiting room. In addition the practice participated in a social prescribing scheme in the area. An information leaflet was available for patients.	

### 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)	92.7%	91.2%	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 the practice website.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The telephone numbers for bereavement counselling and the smoking advice line on the practice website. No further information was available.</p> <p>The waiting area had several noticeboards. These provided information about sexual health centres, support for young families, elderly support, local clubs for young children and general health information.</p> <p>Asthma leaflets were available in Bengali and Gujarati. However, the practice manager told us they found that if patients could not read English they found they could not read in other languages.</p>	

Carers	Narrative
Percentage and number of carers identified.	<p>There were five patients identified as carers. This was 0.1% of the patient population (there were 4,328 patients).</p> <p>During the inspection the practice thought they had eight patients registered as carers. When records were checked it was realised that some had been incorrectly coded. The practice told us they had tried to identify carers but patients had misunderstood the question and thought they were being asked if they were a care worker.</p>
How the practice supported carers.	The practice told us that carers were offered a carer's health check. Two of the five identified carers had had a health check. There was no information about carer's support services on the practice website. There was a carer's noticeboard in the waiting area which gave information about the Oldham carer's service.
How the practice supported recently bereaved patients.	The GP would attend out of hours home visits to certify death so an early funeral could be arranged. Bereavement cards were sent to patients.

## Privacy and dignity

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

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	No
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
Explanation of any answers and additional evidence: Access to the practice nurse's room was via the healthcare assistant's room. Conversations were audible between the rooms. The practice nurse told us that if they needed to carry out cervical screening they asked to use the healthcare assistant's room. There was a window in the door of the healthcare assistant's room so people could see in. There was a folding screen around the couch in the healthcare assistant's room but no curtain was in this room so privacy was compromised.	

## Responsive

## Rating: Requires improvement

### 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 times:	
Monday	8am – 7.30pm
Tuesday	8am – 6.30pm
Wednesday	7.30am – 6.30pm (NB open from 7.30am for nurse appointments only).
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	<u>GPs</u> Open surgery until 10am. 2.10pm – 4.30pm 6.30pm – 7.30pm <u>Nurse</u> 9.30am – 5.15pm
Tuesday	<u>GPs</u> Open surgery until 10am. 3.30pm – 5.30pm <u>Nurse</u> 9.30am – 5.30pm
Wednesday	<u>GPs</u> Open surgery until 10am. Afternoon surgeries by locum GP <u>Nurse</u> 7.30am – 12.30pm
Thursday	<u>GPs</u> Open surgery until 10am.



	2.30pm – 4.30pm <u>Nurse</u> 9.30am – 2.30pm
Friday	<u>GPs</u> Open surgery until 10am. 2.30pm – 5pm
	NB additional locum GP sessions were provided when required. There was some flexibility with GP appointments.

### National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4,330	420	99	23.57%	2.29%

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)	89.8%	93.1%	94.8%	No statistical variation

### Older people

### Population group rating: Requires improvement

#### Findings

Although we saw good practice in this area the responsive domain was rated as requires improvement overall due to a breach of regulation 16 (receiving and acting on complaints). This impacted on all population groups.

- 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.
- Nurse appointments had increased to 30 minutes for patients over the age of 65 to allow time for dementia screening and care plans to be updated.

## People with long-term conditions

## Population group rating: Requires improvement

### Findings

Although we saw good practice in this area the responsive domain was rated as requires improvement overall due to a breach of regulation 16 (receiving and acting on complaints). This impacted on all population groups.

- Patients with multiple conditions had their needs reviewed in one appointment.
- 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.
- Asthma leaflet were available in other languages.

## Families, children and young people

## Population group rating: Requires improvement

### Findings

Although we saw good practice in this area the responsive domain was rated as requires improvement overall due to a breach of regulation 16 (receiving and acting on complaints). This impacted on all population groups.

- Additional nurse appointments were available from 7.30am once a week so appointments were available outside school hours.
- 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 under 5 were offered a same day appointment when necessary.

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

## Population group rating: Requires improvement

### Findings

Although we saw good practice in this area the responsive domain was rated as requires improvement overall due to a breach of regulation 16 (receiving and acting on complaints). This impacted on all population groups.

- 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 7.30pm once a week. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available at the additional location on a Saturday and Sunday.
- Additional nurse appointments were available from 7.30am once a week so appointments were available outside school hours.

## People whose circumstances make them vulnerable

## Population group rating: Requires improvement

### Findings

Although we saw good practice in this area the responsive domain was rated as requires improvement overall due to a breach of regulation 16 (receiving and acting on complaints). This impacted on all population groups.

- The practice held a register of patients living in vulnerable circumstances 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.
- The practice was close to a secure mental health hospital for deaf patients. British sign language translators were available.

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

**Population group rating: Requires improvement**

**Findings**

Although we saw good practice in this area the responsive domain was rated as requires improvement overall due to a breach of regulation 16 (receiving and acting on complaints). This impacted on all population groups.

- 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.
- Dementia training had been carried out for staff approximately four years ago.

**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
Explanation of any answers and additional evidence: There was a daily open surgery between 8am and 10am. All patients attending between these times were seen. There was a system to identify patients who needed to see a GP urgently and these patients were prioritised.	

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)	87.7%	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)	66.7%	69.0%	68.6%	No statistical variation
The percentage of respondents to the GP	68.7%	67.4%	65.9%	No statistical

Indicator	Practice	CCG average	England average	England comparison
patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)				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)	69.4%	72.5%	74.4%	No statistical variation

## Listening and learning from concerns and complaints

### Complaints were not used to improve the quality of care.

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

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	No
<p>Explanation of any answers and additional evidence:</p> <p>Although we saw complaints were looked at in a timely way they were not satisfactorily handled. We were initially told there had been two complaints in the previous 12 months. However, some complaints had been filed in the significant events file, and there had been a complaint the day prior to the inspection that had not yet been recorded. Some complaints were also on the significant event list. Staff recorded complaints on an incident form and then the practice manager decided if it would be treated as a complaint.</p> <p>The complaints procedure, that had been reviewed in January 2019, stated that following the final complaint response the next step was meeting with the GP or practice manager, and then the complainant could approach PALS or the Health Commissioner. The practice manager told us complaints never got that far as they were always resolved.</p> <p>Information about complaints was provided in the practice leaflet. This stated that when investigations had been completed patients would be invited to the practice to try to resolve matters.</p>	

Examples of complaints.

Complaint	Specific action taken
Complaint received 2 July 2018 from a patient as they had been told they could not be seen and thought this was due to an error by the practice.	The practice completed an incident form and recorded "complaint about treatment given". It was recorded that the receptionist told the patient their concerns were not possible. No further action was taken.
Complaint received 19 July 2018 from a patient who felt they had been fobbed off as they had been asked to wait in the waiting area and was not updated.	There was no record of any investigation. A letter was sent to the patient that included "If you are not happy with the service that we provide you are within your rights to move to another surgery". There was no information about how the patient could escalate their complaint if they were unhappy with the response.
Complaint received 4 September 2018 from a patient stating a staff member shouted at them. The written note stated it was a grievance and complaint.	The practice recorded they had tried to contact the complainant by telephone and letter. No further action was taken as the complainant did not respond. The practice manager told us they spoke to the staff member who did not recall the incident. This discussion was not recorded.
Complaint received 2 January 2019 about the attitude of a GP regarding an intimate examination.	It was recorded that as the complaint was about a locum GP the patient needed to give consent for the practice to discuss this with them. The patient had not responded to the request. Nothing else was noted and there had been no follow up action.
Complaint 24 August 2018 from a patient's relative regarding reception not giving information to the relative. It was recorded that this was a complaint.	There was a record of a telephone call to the relative informing them the receptionist had done nothing wrong. No formal response was provided.

## Well-led

**Rating: Inadequate**

### Leadership capacity and capability

**Leaders could not always demonstrate that they had the capacity and skills to deliver high quality sustainable care.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	No
They had identified the actions necessary to address these challenges.	No
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Although there were two GP partners one was not practicing and was not involved in the management or governance of the practice.</p> <p>All staff told us that they were supported by the GPs and practice manager, and there was an open-door policy.</p> <p>The practice manager did not receive support in that they had no cover if they were off work on holiday or due to sickness. They caught up on their work when they returned. They stated that at times they logged on from home when they were off work to deal with practice issues.</p> <p>We were told that clinical meetings were difficult as the salaried GPs worked on different days and the locum GP worked elsewhere as well.</p>	

### Vision and strategy

**The practice had a vision and 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.	Yes
There was a realistic strategy 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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a mission statement: "The high quality of health care we provide will be backed by efficient and effective service, responsive to patient demand and accessible to all".</p>	

## Culture

### The practice culture usually supported high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	No
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
<p>Explanation of any answers and additional evidence:</p> <p>Staff appraisals had been given a low priority and we were told the management were not keen on them as they were not linked to a reward. This mean that competence was not assessed and there was no regular mechanism to discuss staff performance. The practice manager had worked at the practice since 2007 and had never had an appraisal.</p>	

## Governance arrangements

### Responsibilities, roles and systems of accountability to support good governance and management were not always clear.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Staff we spoke with told us they were clear about their roles and responsibilities.</p> <p>We were told that all staff had a job description, but the practice manager was looking at changing these as they had found some things were not being done. They said it was difficult as most staff had the same job so they wouldn't get bored.</p> <p>We discussed the website with the practice manager as we saw some information was incorrect. They told us they had delegated this to a staff member but would have to take back the responsibility. It had not been recognised that some information, including staff information, was incorrect.</p>	



## Managing risks, issues and performance

**The practice did not have clear and effective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
There were processes to manage performance.	No
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.	No
Explanation of any answers and additional evidence:	
<p>The practice had a business continuity plan. It stated that staff would have annual training in incidents and events. We were told this did not occur and there was no formal training. GPs did not keep an updated copy of the business continuity plan. However, we were told they kept an old copy and there were few changes.</p> <p>The fire policy had not been personalised to the practice and some parts were not relevant to the practice. We were told that it had been downloaded from a site and had been in place since August 2017.</p> <p>The practice had carried out its only infection control audit on 30/01/2019. They had scored 87% and the audit results were noted that it would be repeated monthly until they scored a green rating. During the inspection the practice manager stated this was incorrect and it would be repeated quarterly. There was no detail about how the required improvements would be made.</p> <p>Fridge temperature checks were carried out but only the actual temperature was recorded, not the minimum and maximum. The practice had a data logger but the temperatures were set to a minimum of 2°C and 12°C, and not the required 8°C maximum. We saw instances of the maximum temperature being 8.5°C but this had not been actioned due to the incorrect temperature being set. There was no protocol for the action to take if the temperature was outside the required range.</p> <p>We saw evidence of clinical audit taking place. However, some audits were undated, and some had not been reviewed. However, we saw that review dates were in place so clinical audit cycles could be completed.</p>	

## Appropriate and accurate information

**The practice did not always act on appropriate and accurate information.**

	Y/N/Partial
Staff used data to adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	No
Our inspection indicated that information was accurate, valid, reliable and timely.	No
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:	
<p>The practice had systems in place to identify clinical risk. The lead GP was able to identify areas of improvement and risk from the data they had available and made appropriate changes to practice. This included purchasing devices to help with the diagnosis of atrial fibrillation and asthma.</p> <p>We did not see evidence that management systems were in place to support decision making. Staff were not formally assessed and information gathered during the significant event and complaint process was not acted on or used in a way to make changes to systems and processes when required.</p>	

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

**The practice partially 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.	No
Staff views were reflected in the planning and delivery of services.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial
Explanation of any answers and additional evidence:	
<p>The practice had carried out an in-house survey in March 2017. Following this a late-night surgery one day a week had commenced.</p> <p>The practice website stated the practice did not have an active patient participation group (PPG) but would like to form one. It stated a meeting was arranged for January 2018. Another part of the website stated there was a virtual PPG. Practice meeting minutes from September 2018 stated the PPG would meet monthly. However, during the inspection we were told there was not a virtual PPG and the last meeting of the PPG was in December 2017. Due to staffing issues no further meetings had been arranged. The practice manager told us there was not a virtual PPG.</p> <p>We were told that the previous PPG had not been effective as patients had been hand-picked to join and did not contribute to meetings.</p>	

## Continuous improvement and innovation

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.	No
Learning was shared effectively and used to make improvements.	No
Explanation of any answers and additional evidence:	
The process for managing significant events (SEAs) and complaints was unclear. Staff completed an incident form and the practice manager decided if they should be treated as a complaint or SEA. SEAs were not always fully documented, actions required were not clear and reviews were not carried out. Complaints were not dealt with in line with the practice policy. Complainants did not always receive a formal response and not all complaints were investigated. Evidence of learning from SEAs and complaints was not kept.	

### 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 practice's 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.