

Care Quality Commission

Inspection Evidence Table

The Panton Practice (1-569651561)

Inspection date: 26 March 2019

Date of data download: 11 March 2019

Overall rating: Good

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

Safe

Rating: Good

Safety systems and processes

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

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:	

Safeguarding	Y/N/Partial
<p>During our previous inspection (April 2018) we saw that not all staff, including clinicians, had completed safeguarding training. The practice was not able to demonstrate that a Disclosure and Barring Service (DBS) check for an advanced nurse practitioner had been applied for. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).</p> <p>At this inspection we found that all staff had undertaken safeguarding adults and safeguarding children training to the appropriate level.</p> <p>We saw that all relevant staff had a DBS check or a risk assessment, if appropriate, in accordance to the policy and procedure.</p>	

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

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:	Y 19/04/2018
There was a record of equipment calibration. Date of last calibration:	Y 22/01/2019
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:	Y 24/01/2019
There was a log of fire drills. Date of last drill:	Y 17/04/2018
There was a record of fire alarm checks. Date of last check:	Y 21/03/2019
There was a record of fire training for staff. Date of last training:	Y 21/03/2019
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion:	Y 01/12/2016
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: Previously (April 2018) we found that 15 out of 34 staff members had not completed fire safety training. At this inspection we saw that all staff had completed fire safety training. We saw that staff covered the fire safety policy and procedure as part of their induction.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Y 10/02/2019
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Y 10/02/2019

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:	22/01/2019
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: The practice had an infection prevention and control lead who ensured that systems to promote infection prevention and control were regularly reviewed. For example, we saw evidence that the cleaning schedule for the premises and equipment were audited four times per year. The infection prevention and control lead had undertaken an audit to measure adherence to the hand washing policy and procedure. During the audit the lead member of staff ensured that hand washing guidance remained visible next to all sinks and observed the hand washing technique of all staff. Results showed 100% adherence to the hand washing policy and procedure.	

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

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: The practice told us they informed patients to contact the practice if they had not received an appointment within two weeks. This meant that there was not a system in place to ensure patients had been given a hospital appointment if they had been referred to specialist service under the 'two week wait' urgent referral process.	

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)	0.61	0.93	0.94	Variation (positive)
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)	4.0%	8.0%	8.7%	Variation (positive)
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)	5.19	5.63	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)	1.81	3.03	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.	n/a
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	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
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in April 2018 we found that the practice had not recorded serial numbers of prescription stationery received or the distribution of blank prescriptions to clinicians.</p> <p>At this inspection we saw that the practice had implemented a prescription security policy and procedure in April 2018.</p> <p>Allocated staff members were now responsible to record the receipt and distribution of prescription stationery which now included serial numbers. All prescription stationery was stored securely which now included the removal of blank prescriptions from printers at the end of each working day.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	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:	3
Number of events that required action:	3
Explanation of any answers and additional evidence: We saw significant events had been recorded and discussed within staff meetings. Lessons learnt had been shared with all relevant staff.	

Example of significant event recorded and actions by the practice.

Event	Specific action taken
A patient was prescribed an incorrect medicine that had similar spelling to the medicine that they were supposed to be prescribed.	The patient identified the error before taking the medicine. The practice apologised to the patient and prescribed the correct medicine. Staff were reminded to check that the correct medicine had been chosen before printing prescriptions.

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 practice had a record of all safety alerts received by the practice which detailed what action had been taken, by whom and on which date.	

Effective

Rating: Good

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

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)	0.54	0.80	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.
- Health checks were offered to patients over 75 years of age.
- The practice referred people to the local frailty team which supported patients from six practices, including The Panton Practice. Clinical staff from the practice attended multi-disciplinary team meetings every six weeks with the frailty team. The meeting was also attended by district nurses, a community matron and the community mental health team.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- A practice nurse was a chronic disease lead. 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.
- 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)	87.0%	82.9%	78.8%	No statistical variation
Exception rate (number of exceptions).	29.8% (131)	19.9%	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)	74.0%	78.6%	77.7%	No statistical variation
Exception rate (number of exceptions).	21.2% (93)	13.5%	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>	80.6%	81.7%	80.1%	No statistical variation
Exception rate (number of exceptions).	27.3% (120)	18.2%	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>	91.3%	75.9%	76.0%	Significant Variation (positive)
Exception rate (number of exceptions).	26.6% (167)	12.7%	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>	97.3%	91.2%	89.7%	Variation (positive)
Exception rate (number of exceptions).	30.2% (49)	16.6%	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)	79.8%	82.8%	82.6%	No statistical variation
Exception rate (number of exceptions).	9.0% (116)	5.2%	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)	96.3%	89.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	21.8% (38)	7.6%	6.7%	N/A

Any additional evidence or comments

The population group, long term conditions, was rated as requires improvement because, although unverified data showed improvements had been made in the uptake of health checks, results were below local and national indicators.

The practice was aware that exception reporting results were higher than local and national averages for long-term conditions. The practice told us that since our last inspection they had improved the way in which they invited patients for health check appointments which included emailing and/or phoning patients as well as writing to patients on three separate occasions if patients have stated they prefer to be contacted by email or phone.

We saw unverified 2018/19 quality data that showed that the practice had made the following improvements;

- 19% of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months had been exception reported.
- 17% 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 had been exception reported.
- 20% of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less had been exception reported.
- 22% 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 had been exception reported.
- 25% 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 had been exception reported.
- 5% of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less had been exception reported.
- 12% patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anti-coagulation drug therapy had been exception reported.

We saw that GPs were consulted before patients were exception reported. Patients' records demonstrated that reasons for exception reporting had been appropriate.

Families, children and young people

Population group rating: **Good**

Findings

- Childhood immunisation uptake rates were in line with or just below the World Health Organisation (WHO) targets.
- 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)	161	170	94.7%	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)	132	148	89.2%	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)	131	148	88.5%	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)	134	148	90.5%	Met 90% minimum (no variation)

Working age people (including those recently retired and students)

Population group rating: **Good**

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments 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.
- Patients could book or cancel appointments online and order repeat medication 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)	56.0%	74.5%	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)	58.3%	75.9%	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)	53.5%	62.4%	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)	70.3%	62.6%	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)	50.0%	51.6%	51.9%	No statistical variation

Any additional evidence or comments

The practice was aware that the result for the cervical screening indicator was below the 80% Public Health England target for national screening and below local and national averages. The practice had been working to improve uptake of cervical screening by offering a cervical screening clinic between 7am and 8am once a week. The practice had also set up a Saturday morning cervical screening clinic in February 2019 which was reported to be well attended.

The practice showed us unverified data for 2018/19 which showed us that 76% of women eligible for cervical cancer screening had been 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).

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.

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

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- The practice referred patients who were experiencing depression or anxiety to 'Steps to Wellbeing' service which provided talking therapies and self-help workshops. The practice was also able to refer patients who were experiencing drug or alcohol addiction to 'Addaction'.
- 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.
- All staff had received dementia training in the last 12 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)	91.7%	92.2%	89.5%	No statistical variation
Exception rate (number of exceptions).	24.3% (35)	16.7%	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)	86.1%	90.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	20.1% (29)	16.3%	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)	80.7%	84.8%	83.0%	No statistical variation
Exception rate (number of exceptions).	4.2% (5)	6.8%	6.6%	N/A

Any additional evidence or comments

The practice was aware that exception reporting for some mental health indicators was above local and national averages. The practice told us that since our last inspection they had improved the way in which they invited patients for health check appointments which included emailing and/or phoning patients as well as writing to patients on three separate occasions if patients have stated they prefer to be contacted by email or phone.

The practice showed us unverified data for 2018/19 that showed the following improvements;

- 17% of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months, had been exception reported.
- 13% of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months had been exception reported.

We saw that GPs were consulted before patients were exception reported. Patients' records demonstrated that reasons for exception reporting had been appropriate.

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)	550.9	548.8	537.5
Overall QOF exception reporting (all domains)	11.5%	7.0%	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 information about care and treatment to make improvements.	Y

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

The practice had a range of two cycle clinical audits that demonstrated improvements in outcomes for patients. For example, the practice undertook an audit of a prescribed medicine used to treat patients experiencing leg cramps. This was in response to national guidelines recommending a reduction in prescribing of the medicine due to potential side effects. The 39 patients identified as being prescribed the medicine were invited for a review and the potential risks explained to them. This resulted in a reduction of 41% of the original 39 patients being prescribed the medicine.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	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.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Since our last inspection the practice had successfully recruited a salaried GP, a practice nurse and had trained a receptionist to become a health care assistant.</p> <p>At our last inspection in April 2018 we found that the practice did not have an effective overview of staff training and not all staff had completed necessary training.</p> <p>At this inspection we saw that all staff had completed all necessary and specialist training, including safeguarding adults and children training, fire safety training and infection prevention and control training.</p> <p>The practice had an overview system of training which indicated when refresher training was due to be completed. The practice had also implemented an external human resources software programme which alerted managers when staff training was due.</p> <p>We saw that a reception manager had been appointed since our last inspection who monitored that all reception and administrative staff had completed necessary training and refresher training. Staff were allocated protected time to complete all necessary training.</p> <p>All relevant staff had received an appraisal within the last 12 months. All staff who had been appointed in the last 12 months had received a probation review at one, two and three monthly intervals.</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)	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 organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
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

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	91.9%	94.5%	95.1%	No statistical variation
Exception rate (number of exceptions).	3.2% (75)	1.1%	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

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.

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.