

Care Quality Commission

Inspection Evidence Table

St James Medical Centre (1-567780409)

Inspection date: 8 and 9 May 2019

Date of data download: 01 May 2019

Overall rating: Good

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

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
Until April 2019 the practice had taken part in the Somerset Practices Quality Scheme (SPQS) rather than the Quality and Outcomes Framework (QOF). (QOF is a system intended to improve the quality of general practice and reward good practice). SPQS measured quality and outcomes differently with an emphasis on quality improvement for a reduced number of indicators. Under the SPQS framework reporting on some indicators such as the QOF data below which showed a negative variation were not included meaning the negative variation in achievement shown were not representative.	
During inspection, we saw that clinicians were supported by clear clinical pathways and protocols. For example, they used a bespoke template and clinical pathway system (Q Master) which ensured	

improvement in the quality of the data within patient records. The system ensured appropriate coding of treatment provided in line with QOF.

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) (01/01/2018 to 31/12/2018) <small>(NHSBSA)</small>	0.94	0.68	0.79	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. For example, both nurse practitioners had experience of treating patients with multiple and complex needs.
- Home visits including regular attendance at residential and nursing homes were undertaken for those who found attendance at the surgery difficult.
- Patients had access to a wellbeing advisor for signposting, support and social prescribing.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. They had comprehensive care plans in place.
- 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.
- Patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma were followed up.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions such as diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. For example, pre-diabetic screening and reviews were in place.
- 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.
- A text alert recall system was in place to remind patients they required long term medicine

monitoring. The practice had arrangements for following up failed attendance for monitoring of high-risk medicines.

- Staff signposted patients to relevant NHS support technology such as 'my diabetes, my way'.

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>	66.5%	70.0%	78.8%	Tending towards variation (negative)
Exception rate (number of exceptions).	3.9% (27)	7.3%	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>	67.3%	67.4%	77.7%	No statistical variation
Exception rate (number of exceptions).	4.9% (34)	6.1%	9.8%	N/A
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>	73.0%	75.5%	80.1%	No statistical variation
Exception rate (number of exceptions).	8.9% (62)	10.7%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	48.1%	61.3%	76.0%	Significant Variation (negative)
Exception rate (number of exceptions).	2.9% (27)	6.9%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	74.1%	68.8%	89.7%	Variation (negative)
Exception rate (number of exceptions).	4.4% (12)	7.1%	11.5%	N/A

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)	79.2%	76.2%	82.6%	No statistical variation
Exception rate (number of exceptions).	3.4% (66)	3.6%	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)	79.6%	86.3%	90.0%	Variation (negative)
Exception rate (number of exceptions).	2.3% (6)	3.8%	6.7%	N/A

Any additional evidence or comments

During inspection we reviewed the most recent data (April 2019, when the practice joined the Quality and Outcomes Framework QOF):

- The percentage of patients with COPD (Chronic Obstructive Pulmonary Disease) who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness was 95%.
- 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 was 84% (target 70%).
- We saw the practice had undertaken a medical records review for patients with a diagnosis of atrial fibrillation. All patients were receiving the appropriate care and treatment.
- The practice had templates in place for management of long term conditions. The practice had templates in place for management of long term conditions. We reviewed these templates and found they had been updated to include an assessment of asthma control using all three of the standard questions recommended by the Royal College of Physicians.
- All QOF areas had a lead GP and a QOF team were in place to review coding, achievements, update templates and work within the Q Master system.
- On inspection, we found QOF indicators (above) were not representative of the care and treatment provided to patients with a long term condition due to the practice using a local quality improvement scheme that weighted less on the completion of specific QOF indicators. The practice was taking action to ensure all coding for conditions and treatment were reviewed and changed accordingly.
- Evidence we reviewed including asthma and diabetic templates used for condition management were in line with best practice quality guidance and demonstrated delivery of effective person centred care.

Findings

- Childhood immunisation uptake rates were in line with or slightly 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. Clinical staff fitted contraceptive implants and intra-uterine devices.

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)	164	182	90.1%	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)	200	213	93.9%	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)	204	213	95.8%	Met 95% WHO based target (significant variation positive)
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)	203	213	95.3%	Met 95% WHO based target (significant variation positive)

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. The practice provided evening and weekend appointments as well as Engage Consult which provides access to services online from a PC, tablet or smartphone.

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)	72.5%	73.9%	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)	62.6%	73.9%	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)	59.0%	61.1%	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)	15.7%	45.1%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	60.0%	54.8%	51.9%	No statistical variation

Any additional evidence or comments

During inspection, we reviewed current data for cervical smears as data for 2017/18 showed the practice was below the 80% target for national screening:

- Of the 3,209 patients eligible for screening 2,470 had been screened (77% of eligible patients).
- Staff whose role included taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice had systems in place to encourage patients to attend screening such as a text alert service, alerts on patient records when a smear was due and additional invitation letters when patients did not book appointments.

We reviewed current data and found the percentage of patients with cancer, diagnosed within the

preceding 15 months, who had a patient review recorded as occurring within 6 months of the date of diagnosis was 96% (Target 90%).

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 used the Gold Standard Framework to deliver palliative care, including a comprehensive template to record discussions about patient needs, wishes and preferences. A digital record system EPaCCs (Electronic Palliative Care Coordination Systems) was in place for organisations to access an individual's care preferences and key details about their care.
- The practice held a register of patients living in vulnerable circumstances including homeless people, housebound patients 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 had comprehensive care plans in place which included treatment escalation plans (Somerset TEP), next of kin, carers information and relevant assessments such as frailty and fall assessments.
- The nurse practitioner carried out home visits and annual reviews for people with a learning disability. At the time of inspection 69% of patients had been reviewed.
- Staff had received additional training to support patients and their families fleeing domestic violence and abuse.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- There was a system for following up patients who failed to attend for administration of long-term medication. Patients requiring regular injections to treat their diagnosis were able to have these administered at the practice.
- 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.
- The practice hosted trainee counsellors which enabled patients to have faster support to coping mechanisms whilst awaiting referral to Talking Therapies.

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)	15.8%	39.1%	89.5%	Significant Variation (negative)
Exception rate (number of exceptions).	3.9% (6)	6.6%	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)	33.6%	47.3%	90.0%	Significant Variation (negative)
Exception rate (number of exceptions).	5.9% (9)	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)	92.3%	52.1%	83.0%	No statistical variation
Exception rate (number of exceptions).	6.0% (5)	6.9%	6.6%	N/A

Any additional evidence or comments

Until April 2019 the practice took part in the Somerset Practices Quality Scheme (SPQS) rather than the Quality and Outcomes Framework (QOF). (QOF is a system intended to improve the quality of general practice and reward good practice). SPQS measures quality and outcomes differently with an emphasis on quality improvement for a reduced number of indicators.

QOF scores showed some negative variations (worse than national averages) for most mental health targets. We found the practice had reviewed coding for episodes of contact with patients and improved the coding to ensure any contact with patients was appropriately recorded.

We looked at current data for 2018/19 which showed:

- 93% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record. (Target 90%).
- 95% of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded. (Target 90%).
- All patients diagnosed with dementia had a care plan in place and had received a face-to-face review in the preceding 12 months. (Target 70%).

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)	399.6	423.2	537.5
Overall QOF exception reporting (all domains)	3.9%	4.0%	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

<p>The practice had undertaken quality improvement and audit work. These included annual minor surgery and intra-uterine device audits; atrial fibrillation and anticoagulation audit and a peer review of referrals for ongoing care and treatment. We reviewed audits and saw two cycle audits with better patient outcomes. Examples of audits seen:</p> <ul style="list-style-type: none"> • The aim of the ophthalmology audit was to analyse the time taken for the referral to be processed. As a result, the steps within the practice process was reviewed to enable a more time-efficient referral. • An audit reviewing patients with atrial fibrillation (AF) and whether they were taking medicines to reduce the risk of a stroke. As a result of the first cycle audit, new patients or those with AF diagnosed outside of the practice were invited in for regular clinical reviews. • An audit reviewing injectable medicines for osteoporosis resulted in implementation of a recall and safety monitoring system and where necessary a clinical review. • In addition, multiple audits for the dermatology service were undertaken annually. These included health and safety risk assessments, reviews of any adverse outcomes and all treatment as well as the process to manage and gain patient consent.

Any additional evidence or comments

We saw follow-up consultations took place following a hospital discharge. Patient records we reviewed showed comprehensive reviews of care and treatment took place.

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
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
<ul style="list-style-type: none"> • The practice understood the learning needs of staff and provided protected time and five training days annually to meet clinical staff needs. Staff were encouraged and given opportunities to develop. For example, the practice was funding a nurse prescribing course and had funded a minor surgery course for the nurse practitioner. • The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing. Nurse practitioners had a mentor who undertook clinical supervision and clinical reviews of patient records. They could demonstrate the prescribing competence of non-medical prescribers. • Three GPs took on educational and clinical supervisor roles for trainee doctors, GP trainees and nurse practitioners. 	

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
<ul style="list-style-type: none"> • Patients received coordinated and person-centred care. This included when they moved between services, when they were re-referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies. • The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. • The practice provided a dermatology service for the County as secondary care dermatology had ceased in the area. One GP provided a skin cancer clinic and a dermatology clinic reducing peoples need to travel outside the County for the service. Since September 2018 1,362 patients had been seen of which 981 patients were managed on a single appointment. Approximately 143 patients required referral to a specialist consultant either due to limitations within the practice to manage certain surgical procedures or for urgent secondary care. • The additional expertise held by the GP meant patient's registered at the practice were able to see a doctor they knew when referred for specialist care and specialist knowledge in skin disease was accessible to those patients registered with the practice and staff. 	

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
<ul style="list-style-type: none"> The practice had identified 4% of patients as carers. This included those patients' who had caring responsibilities with people not registered at the practice. Staff helped patients and their carers find further information and access community and advocacy services. The practice (as part of Somerset Clinical Commissioning Group funding) had a wellbeing advisor to support individuals to gain greater control of their own health and wellbeing. This included signposting to other agencies such as social care and social prescribing and attendance at the local talking café. 	

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>	99.7%	89.6%	95.1%	Significant Variation (positive)
Exception rate (number of exceptions).	0.7% (24)	1.1%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	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
<ul style="list-style-type: none">• The practice monitored the process for seeking consent with audits undertaken of the intrauterine device, minor surgery and dermatology services.• Staff had received Mental Capacity Act & consent training including Deprivation of Liberty training.• Appropriate templates were in place to assess a patient's mental capacity if there were concerns around their ability to consent to treatment.	

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders could 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.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<ul style="list-style-type: none">• Leaders had the experience, capability and integrity to deliver the practice strategy and address risks to it.• They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.• Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.• The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.• GPs took on additional roles with the Local Medical Committee and Primary Care Network.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Mission: To care for sick and vulnerable, to be accessible, to encourage patients to be responsible for their own health. Core values: high quality and caring service, safe and efficient system, happy well-trained staff teams, forward thinking. Vision: HAPPI (Health and safety compliant, Act for the vulnerable, Patient care, Prevention of illness and integrity of data held).	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
<ul style="list-style-type: none"> • Staff stated they felt respected, supported and valued. They were proud to work in the practice. • Leaders and managers acted on behaviour and performance inconsistent with the vision and values. • Openness, honesty and transparency were demonstrated when responding to incidents and complaints. • Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. • There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary. • Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work. • There was a strong emphasis on the safety and well-being of all staff. • The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally. • There were positive relationships between staff and teams. • Staff were proud that they were accessible to patients by demonstrating no more than a week's wait for a routine named GP appointment. 	

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

Source	Feedback
Staff interviews, and non-clinical staff focus group.	Staff told us: <ul style="list-style-type: none"> • they enjoyed working at the practice and felt valued and cared for by practice leaders. • they were always able to discuss any changes or concerns and had the autonomy of decisions. • Relevant training and support was made available.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>As part of this inspection we reviewed governance processes and found:</p> <ul style="list-style-type: none"> • There were comprehensive risk assessments in relation to safety issues. • The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements. • Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The practice had recently implemented a technology-based governance system to ensure safety and assured themselves that they were operating as intended. The system provided up-to-date reference information, procedures and policies, appraisals and health and safety risk management. • Staff were clear about their roles and accountabilities including infection prevention and control (IPC). We reviewed the governance of IPC and found appropriate standards of cleanliness and hygiene were met. • There were adequate processes and emergency equipment to assess, monitor and manage risks. There was equipment available to enable assessment of patients with presumed sepsis or another clinical emergency. The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases. There was medical oxygen and a defibrillator at both sites and systems to ensure these were regularly checked and fit for use. 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. • Complaints were listened and responded to and used to improve the quality of care. We reviewed two of the 18 complaints received by the practice (January to December 2018) and found they were satisfactorily handled in a timely way. • The practice held a daily meeting before opening. Staff were updated on daily specifics such as the duty doctor, consultation room occupants, visiting services, problems in the past 24 hours such as immunisation shortages, significant events and complaints. Informal minutes were available for all staff not in attendance. • We found the governance and management of the dermatology service to be comprehensive with staff involved having clear understanding around roles and responsibilities. The lead GP had undergone specialist training to provide appropriate care and treatment. We reviewed the assurance systems in place along with patient records, finding them effective with high quality patient outcomes. 	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<ul style="list-style-type: none"> The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. Administrative staff had received signposting training to direct patients to the most appropriate service. The practice had implemented workflow optimisation with each GP having a named personal assistant. By upskilling staff, they had reduced time clinicians spent on administrative tasks by 75% and allowed for consistent coding for QOF (Quality Outcome Framework) indicators. The team took part in regular audit and clinical oversight which demonstrated staff competency and improved management of clinical processes through accomplishment of tasks. The practice demonstrated learning from significant risks such as an IT outage. As an outcome each practice has accessible paper records and a communication process between each site for use in incidents that effect the running of the service. 	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

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

entails.	
<ul style="list-style-type: none"> • Quality and operational information was used to ensure and improve performance. For example, the practice had an IT development lead. As part of the role they had produced a directory of coding to assist in workforce optimisation. They had a core group of staff from different teams acting in a QOF (quality and outcomes framework) role to improve clinical performance. • Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information. • The practice used information technology systems to monitor and improve the quality of care. • There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. 	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<ul style="list-style-type: none"> • Patient and staff feedback were discussed at the monthly GP partners meeting. • The practice had a virtual patient participation group (PPG). 	
Any additional evidence	
<p>During the inspection we spoke to seven patients. They told us:</p> <ul style="list-style-type: none"> • They could see a GP of their choice. • They could get an appointment when they needed one. • Clinical staff listened to them and understood their wishes. Staff involved them in discussions about their care and treatment including referrals to other services. <p>We received 15 completed CQC comment cards. Thirteen were positive about the service with two providing mixed views about the service Patients told us they were always able to get an appointment and the care they received was excellent.</p> <p>The National GP Patient Survey results (2018) showed the practice was in line with or above local and national averages. Of the 300 surveys the practice had a 42% response rate (0.78% of practice population):</p> <ul style="list-style-type: none"> • The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice was 94% compared with the CCG (86%) and National (84%) averages. • The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met was 99.4% (CCG 95.9% National 94.8%). • The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times was 84% (CCG 67%, National 65.9%). 	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<ul style="list-style-type: none">• The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. For example, following a patient letter being sent to the wrong patient the practice wrote to the Information Commissioners Office (ICO) and implemented their recommendations. Following the incident, the practice signed up for the Data Security and Protection Toolkit (an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards).• Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.• The practice engaged in the use of digital technology to improve patient care and treatment such as such EPaCCs (Electronic Palliative Care Coordination Systems).• They were part of the Engage Consult project. (Engage Consult allows patients and carers to connect with their GP practice and access services online from a PC, tablet or smartphone. It can support the management of demand and capacity within a practice and offers patients an additional option for communicating with their surgery for booking appointments, ordering repeat prescriptions and having an online consultation.• They took part in projects and pilots. For example, the new quality and outcomes framework (QOF) indicators pilot.• They hosted and provided services to improve patient access such as talking therapies, trainee counsellors and dermatological services for the County.• The practice has received an excellence rating from the local postgraduate medical education centre for the support and training provided to GP trainees (registrars) and year two foundation doctors (medical graduates in a junior doctor role). We saw the practice had an emphasis on quality training of staff and postgraduate GPs. This impacted positively on the practice clinicians as three partners were engaged with the training programme meaning they were constantly learning and updating their skills / knowledge.	

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 Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- 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.