# Care Quality Commission

## Inspection Evidence Table

## Haydock Medical Centre (1-4576695451)

**Inspection date: 13 June 2019**

**Date of data download:** 20 June 2019

## Overall rating: Requires improvement

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

## Safe                                     Rating: Requires improvement

**Safety systems and processes**

**The practice had systems, practices and processes in place 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 which were accessible to all staff. | Y |
| Policies and procedures were monitored, reviewed and updated. | Y |
| Partners and staff were trained to appropriate levels for their role. | Y |
| There was active and appropriate engagement in local safeguarding processes. | Y |
| The Out of Hours service was informed of relevant safeguarding information. | Y |
| There were systems to identify vulnerable patients on record. | 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: <ul><li>A register of children at risk was in place and this was reviewed with health visitors to ensure the information held was up to date.</li><li>Alerts were recorded on the electronic patient records system to identify if a child or adult was at risk. However, this did not always include identifying other household members.</li></ul> | |

| Safeguarding | Y/N/Partial |
|---|---|

- There was a lead member of staff for safeguarding.
- All staff had received up-to-date safeguarding training appropriate to their role.
- Staff we spoke with knew how to identify and report concerns, and they told us they took steps to protect patients from abuse, including regular contact and meetings with other agencies.
- Staff who had undergone a Disclosure and Barring Service (DBS) check. (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.)
- A system was in place to ensure all policies and procedures including safeguarding were regularly reviewed and staff had ready access to all policies and procedures.

| 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 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 |

Explanation of any answers and additional evidence:

- Staff recruitment processes included ensuring appropriate pre-employment checks had been carried out prior to staff appointments.
- All clinical staff were up to date with their revalidation and registration. A system to monitor this was not in place.
- Confirmation was provided that medical indemnity cover was in place for the clinical team.

| Safety systems and records | Y/N/Partial |
|---|---|
| There was a record of portable appliance testing or visual inspection by a competent person.<br>Date of last inspection/test: 26/07/2018 | Y |
| There was a record of equipment calibration.<br>Date of last calibration: 19/07/2018 | Y |
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | Partial |
| There was a fire procedure. | Y |
| There was a record of fire extinguisher checks.<br>Date of last check: 12/06/2019 | Y |
| There was a record of fire alarm checks.<br>Date of last check: 12/06/2019 | Y |
| There was a record of fire training for staff.<br>Date of last training: 07/06/2019 | Y |
| There were fire marshals. | Y |
| A fire risk assessment had been completed.<br>Date of completion: February 2019 | Y |
| Actions from fire risk assessment were identified and completed. | Partial |
| Explanation of any answers and additional evidence:<br><br>• COSHH data sheets were available and cleaning chemicals were stored securely but there was no risk assessment linked to how these were managed. The practice manager told us the provider was commissioning a health and safety assessment for all areas of work. Following the inspection, the provider told us that a risk assessment had been carried out by the cleaning company but this had not been provided to us during the course of the inspection visit.<br><br>• Actions required from the fire risk assessment had been actioned or reported to the property owner and were awaiting action. | |

| Health and safety | Y/N/Partial |
|---|---|
| Premises/security risk assessment had been carried out.<br>Date of last assessment: 20/05/2019 | Y |
| Health and safety risk assessments had been carried out and appropriate actions taken.<br>Date of last assessment: | Y |
| Explanation of any answers and additional evidence:<br><br>• Health and safety related policies and procedures were in place. A basic health and safety risk assessment had been carried out on 12/06/2019. The practice manager informed us that a health and safety specialist was being brought in to carry out a more comprehensive assessment. | |

**Infection prevention and control**

## Appropriate standards of cleanliness and hygiene were met.

| | Y/N/Partial |
|---|---|
| There was an infection risk assessment and policy. | Y |
| Staff had received effective training on infection prevention and control. | Y |
| Infection prevention and control audits were carried out.<br>Date of last infection prevention and control audit: 05/12/2018 | Y |
| The practice had acted on any issues identified in infection prevention and control audits. | Y |
| The arrangements for managing waste and clinical specimens kept people safe. | Y |
| Explanation of any answers and additional evidence:<br><br>• The practice was presented as clean and hygienic.<br>• Personal protective equipment was readily available to staff.<br>• Arrangements were in place for managing clinical waste and specimens. | |

**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 |
| The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures. | 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 |
| When there were changes to services or staff the practice assessed and monitored the impact on safety. | Y |
| Explanation of any answers and additional evidence: | |

**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 and 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 |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | 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 had introduced new procedures for checking that all referrals made under the two-week rule were followed up to ensure they had been attended.

- The provider had carried out an audit of letters received about patient care, for example hospital discharge letters, as there had been several events whereby important information had not been handled appropriately before being stored on patient records. All staff had also been reminded of the standard operating procedures for this.

**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) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA) | 1.16 | 1.05 | 0.88 | Tending towards variation (negative) |
| 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). (01/04/2018 to 31/03/2019) (NHSBSA) | 7.0% | 7.0% | 8.7% | No statistical variation |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2018 to 31/03/2019) (NHSBSA) | 6.27 | 5.96 | 5.61 | No statistical variation |
| Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA) | 2.21 | 2.65 | 2.07 | 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. | Partial |
| 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. | Partial |
| 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 |
| 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. | NA |
| 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 |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Y |
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective. | Y |
| Explanation of any answers and additional evidence: <ul><li>The provider told us that there was an ongoing programme of mentoring in place for non-medical prescribers. However, this was not documented and formalised.</li><li>An appropriate system was not in place for the security of prescription forms in line with national guidance.</li><li>Regular medicines audits were carried out with the support of the local clinical commissioning group (CCG) pharmacy team.</li><li>Medicines prescribing data for the practice was generally comparable to national prescribing data although higher than local and national averages in some areas, particularly for antibiotic prescribing.</li><li>The practice made improvements to prescribing in line with best practice guidance and targets to reduce the prescribing of medicines.</li><li>There was a system for monitoring patients who were prescribed high risk medicines.</li></ul> | |

| Dispensary services (where the practice provided a dispensary service) | Y/N/Partial |
|---|---|
| There was a GP responsible for providing effective leadership for the dispensary. | N/A |
| The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance. | N/A |
| Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency. | N/A |
| Prescriptions were signed before medicines were dispensed and handed out to patents. There was a risk assessment or surgery policy for exceptions such as acute prescriptions. | N/A |
| Medicines stock was appropriately managed and disposed of, and staff kept appropriate records. | N/A |
| Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective. | N/A |
| If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines. | N/A |
| If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability. | N/A |
| Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence. | N/A |
| Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc. | N/A |
| There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians. | N/A |
| Explanation of any answers and other comments on dispensary services: | |

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

## The practice had not always learnt 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. | Partial |
| 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. | Partial |
| Staff understood how to raise concerns and report incidents both internally and externally. | Y |
| There was evidence of learning and dissemination of information. | N |
| Number of events recorded in last 12 months: | 25 |
| Number of events that required action: | 25 |
| Explanation of any answers and additional evidence: | |

- The system for managing and acting on significant events was not effective. The documenting of events was poor and failed to demonstrate fully the outcome of the investigation, the learning and the actions taken to prevent a reoccurrence. Events were a standard agenda item at clinical meetings, but the minutes of meetings did not reflect that events and the learning from these had been shared and disseminated appropriately. As a result, we found that the nature of a number of events linked to patient safety had reoccurred. The referencing of events was not always consistent, and this made tracking the actions taken difficult. The practice manager informed us that they had recognised the shortfalls in the management of events and had commenced a review of events to ensure all appropriate actions had been taken and completed. Following the inspection, the provider submitted details of how they intended to improve the system and review documented events.

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

| Event | Specific action taken |
|---|---|
| Hospital discharge letter filed inappropriately. | This had happened on several occasions before the provider carried out an audit to assess the extent of the problem and took action to make improvements. |
| Missed referral to secondary care. | This was investigated and the system for tracking referrals made under the two week wait rule was developed. This had happened on a number of occasions before the system was improved. |

| Safety alerts | Y/N/Partial |
|---|---|
| There was a system for recording and acting on safety alerts. | Partial |
| Staff understood how to deal with alerts. | Partial |

Explanation of any answers and additional evidence:

- The system in place for recording and acting on patient safety alerts was not robust as there was no clear audit trail and sign off to show all alerts had been appropriately actioned. Alerts were passed to the clinical team by the practice manager and discussed in clinical meetings and we saw an example of action taken regarding the prescribing of sodium valproate. The provider told us that all alerts had been acted on. However, the system for managing and evidencing this was not sufficiently robust to demonstrate the actions taken for all relevant alerts.

# 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 |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | 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 to make sure that patients' needs were addressed. | Y |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Y |
| Explanation of any answers and additional evidence: | |

| 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) (01/04/2018 to 31/03/2019) (NHSBSA) | 1.09 | 1.49 | 0.77 | No statistical variation |

## Older people                          Population group rating: Good

| Findings |
|---|
| <ul><li>The practice kept up to date registers of patients with a range of health conditions (including conditions common in older people) and used this information to plan reviews of health care and to offer services such as vaccinations for flu.</li><li>Nationally reported data showed that outcomes for patients with conditions commonly found in older people at this practice were generally comparable to outcomes for patients locally and nationally. Exception reporting under the Quality Outcome Framework (QOF) was higher than average in a number of areas.</li><li>The practice carried out structured annual medication reviews for older patients.</li><li>Health checks were offered to patients over 75 years of age.</li></ul> |

- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group. Flu vaccinations were provided to patients who were housebound.

- On the day appointments allowed for rapid access to meet the needs of older patients with co-morbidities.

- The practice used the 'Gold Standard Framework' (this is a systematic evidence-based approach to improving the support and palliative care of patients nearing the end of their life) to ensure patients received appropriate care.

- Staff had been provided with training in dementia awareness and disability awareness.

- The practice hosted a number of local community exercise and wellbeing groups.

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

### Findings

- The practice held information about the prevalence of specific long-term conditions within its patient population. This included conditions such as diabetes, chronic obstructive pulmonary disease (COPD), cardio vascular disease and hypertension. The information was used to target service provision, for example to ensure patients who required immunisations received these.
- The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening their clinical record.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. Patients with multiple conditions were reviewed in one visit where possible. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Home visits were provided to patients who had difficulty getting to the practice.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Data from 2017 to 2018 showed that the practice was generally performing comparably to practices locally and nationally for the care and treatment of people with chronic health conditions.
- Clinical staff who were responsible for reviewing the needs of patients with long term conditions had received training appropriate to their role.
- Patients were provided with advice and guidance about prevention and management of their health conditions and were signposted to support services.
- Information to help patients understand, prevent and manage conditions was displayed in waiting areas and patient information leaflets were readily available.
- Fifteen-minute appointments were provided as standard and double appointments were provided when required.
- The practice provided in-house spirometry, ECG and ambulatory blood pressure monitoring and this could also be provided to patients in their own home if this was necessary.

| 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 | 82.8% | 83.3% | 78.8% | No statistical variation |

| | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF) | | | | |
| Exception rate (number of exceptions). | 12.9% (67) | 17.0% | 13.2% | N/A |
| The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF) | 65.1% | 81.4% | 77.7% | Tending towards variation (negative) |
| Exception rate (number of exceptions). | 13.1% (68) | 10.9% | 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) (QOF) | 81.0% | 82.5% | 80.1% | No statistical variation |
| Exception rate (number of exceptions). | 13.1% (68) | 15.4% | 13.5% | N/A |

| Other long-term conditions | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF) | 87.8% | 78.8% | 76.0% | Variation (positive) |
| Exception rate (number of exceptions). | 20.7% (115) | 13.6% | 7.7% | N/A |
| The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF) | 90.8% | 91.5% | 89.7% | No statistical variation |
| Exception rate (number of exceptions). | 15.5% (36) | 13.7% | 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) | 81.6% | 84.7% | 82.6% | No statistical variation |
| Exception rate (number of exceptions). | 6.5% (87) | 3.7% | 4.2% | N/A |
| In those patients with atrial fibrillation with a | 93.0% | 89.1% | 90.0% | No statistical |

| 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) | | | | variation |
|---|---|---|---|---|
| Exception rate (number of exceptions). | 11.7% (19) | 4.7% | 6.7% | N/A |

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

| Findings |
|---|
| <ul><li>Childhood immunisation uptake rates were very close to the World Health Organisation (WHO) targets.</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.</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>Young people could access services for sexual health and contraception.</li><li>There were systems in place to identify and follow up children who were at risk.</li><li>A designated lead was in place for safeguarding.</li><li>Staff had undergone regular safeguarding training and those we spoke with had appropriate knowledge about child protection and had ready access to safeguarding policies and procedures.</li><li>Safeguarding concerns were discussed at multi-disciplinary meetings.</li><li>The waiting area and clinical rooms were child friendly.</li></ul> |

| Child Immunisation | Numerator | Denominator | Practice % | Comparison to WHO target of 95% |
|---|---|---|---|---|
| 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) | 84 | 88 | 95.5% | 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) | 70 | 78 | 89.7% | 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) | 69 | 78 | 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) | 70 | 78 | 89.7% | Below 90% minimum (variation negative) |

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information:
https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

## Any additional evidence or comments

- The practice had arrangements for following up failed attendance for childhood immunisations and would liaise with health visitors when necessary.

## Working age people (including those recently retired and students)       Population group rating: Good

## Findings

- The practice's encouraged cancer screening uptake for patients in this age group. Uptake rates were comparable to local and national averages.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- Patients were able to use request a telephone consultation and therefore did not always have to attend the practice in person to seek advice, and care and treatment.
- The practice started to provide E-Consult on line consultations in May 2019.

| 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) | 69.5% | 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) | 74.9% | 73.3% | 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) | 58.7% | 57.6% | 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) | 59.6% | 79.0% | 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) | 39.0% | 49.7% | 51.9% | No statistical variation |

| Any additional evidence or comments |
|---|
|  |

## People whose circumstances make them vulnerable

## Population group rating: Good

| Findings |
|---|

- The practice held a register of patients living in vulnerable circumstances in order to provide the services patients required. For example, a register of people who had a learning disability was maintained to ensure patients were provided with an annual health check.

- Same day appointments and longer appointments were offered when required.

- End of life care was delivered in a co-ordinated way which took into account the needs of those whose circumstances may make them vulnerable.

- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

- Staff had been provided with training in the forms of abuse and how to recognise it in vulnerable adults.

- Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of

hours.

- The practice provided appropriate access and facilities for people who were disabled.
- Information and advice was available about how patients could access a range of support groups and voluntary organisations.
- Multi-disciplinary meetings were held and patients care and treatment needs were discussed amongst other relevant health professionals.

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

### Population group rating: Good

**Findings**

- The practice held a register of patients experiencing poor mental health and these patients were offered an annual review of their physical and mental health.
- Data about how people with mental health needs were supported showed that outcomes for patients using this practice were comparable with local and national averages
- The practice assessed and monitored the physical health of people with mental illness.
- Same day and longer appointments were offered when required.
- 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.
- Staff had received dementia care training.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- A system was in place to prompt patients for medicines reviews at intervals suitable to the medicines they were prescribed.
- One of the advance nurse practitioners was experienced in mental health and held a lead in this in the practice. Feedback from patients about this was very positive.
- The practice provided or hosted a range of therapeutic support to patients.

| 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) | 91.3% | 89.2% | 89.5% | No statistical variation |
| Exception rate (number of exceptions). | 37.8% (28) | 14.6% | 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) | 91.1% | 91.1% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 39.2% (29) | 12.3% | 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) | 73.8% | 81.3% | 83.0% | No statistical variation |
| Exception rate (number of exceptions). | 14.5% (11) | 8.2% | 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) | 549.2 | 547.2 | 537.5 |
| Overall QOF score (as a percentage of maximum) | 98.2% | 97.9% | 96.2% |
| Overall QOF exception reporting (all domains) | 8.7% | 6.7% | 5.8% |

| | Y/N/Partial |
|---|---|
| Clinicians took part in national and local quality improvement initiatives. | Y |
| The practice had a programme of quality improvement and used information about care and treatment to make improvements. | Y |
| Quality improvement activity was targeted at the areas where there were concerns. | Y |
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action. | Y |

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

past two years

Clinical audits were carried out to improve outcomes for patients. Clinical audit is a way to find out if the care and treatment being provided is in line with best practice and it enables providers to know if the service is doing well and where they could make improvements. The aim is to promote improvements to the quality of outcomes for patients. We viewed two audits that demonstrated that the provider had assessed and made improvements to the treatment provided to patients.

The audits we viewed related to safe prescribing practices and ensuring requirements for regular checks were made on the effects of medicines and ensuring medicines breaks in line with repeat prescribing guidance.

**Any additional evidence or comments**

**Effective staffing**

## Systems for demonstrating that staff had the skills, knowledge and experience to carry out their roles were not formalised appropriately for all staff.

|  | Y/N/Partial |
|---|---|
| Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme. | Y |
| The learning and development needs of staff were assessed. | Y |
| The practice had a programme of learning and development. | Y |
| Staff had protected time for learning and development. | Y |
| There was an induction programme for new staff. | Y |
| Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015. | N/A |
| 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. | Partial |
| Explanation of any answers and additional evidence: <br><br> • There was no formal system in place for the regular review/ monitoring of the prescribing competence of non-medical prescribers or demonstrating their competence. The provider told us this was provided but had not been recorded. | |

**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 |
| Explanation of any answers and additional evidence: | |

**Helping patients to live healthier lives**

## Staff were 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 |
| Patients had access to appropriate health assessments and checks. | Y |
| Staff discussed changes to care or treatment with patients and their carers as necessary. | Y |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity. | Y |
| Explanation of any answers and additional evidence: <ul><li>Health promotion information and information and advice about how patients could access a range of support groups and voluntary organisations was available in the reception and waiting area.</li></ul> | |

| 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 | 95.8% | 95.6% | 95.1% | No statistical variation |

| other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF) | | | | |
|---|---|---|---|---|
| Exception rate (number of exceptions). | 3.1% (68) | 1.1% | 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. | 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 |
| Policies for any online services offered were in line with national guidance. | Y |
| Explanation of any answers and additional evidence: | |

# Caring                                    Rating: Good

**Kindness, respect and compassion**

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

| | Y/N/Partial |
|---|---|
| Staff displayed understanding and a non-judgemental attitude towards patients. | Y |
| Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition. | Y |
| Explanation of any answers and additional evidence: | |

| CQC comments cards | |
|---|---|
| Total comments cards received. | 22 |
| Number of CQC comments received which were positive about the service. | 22 |
| Number of comments cards received which were mixed about the service. | 0 |
| Number of CQC comments received which were negative about the service. | 0 |

| Source | Feedback |
|---|---|
| CQC comment cards | Feedback received in CQC comment cards was very positive in all areas and in particular about how patients felt cared for and well treated by staff. |
| Discussions with patients | We spoke with four patients during the course of the inspection. All feedback received was positive. |
| NHS Friends and Family test results | Results of the NHS Friends and Family test were positive with a high proportion of respondents likely to recommend the practice. |

**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 |
|---|---|---|---|---|
| 7472 | 271 | 117 | 43.2% | 1.57% |

| 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) | 97.4% | 90.6% | 89.0% | Variation (positive) |
| 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) | 87.4% | 88.8% | 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) | 97.4% | 95.3% | 95.6% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018) | 75.8% | 83.8% | 83.8% | No statistical variation |

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

| Any additional evidence |
|---|
| • We spoke with four patients and they gave us positive feedback about the caring nature of the service and their experiences of the care and treatment provided. Patients were complementary about the staff team for all roles. |

**Involvement in decisions about care and treatment**

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

|  | Y/N/Partial |
|---|---|
| Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given. | Y |
| Staff helped patients and their carers find further information and access community and advocacy services. | Y |
| Explanation of any answers and additional evidence:<br>• An interpretation service was available for patients who required this.<br>• The provider was aware of the accessible information standards and told us they were aware of and met the communication needs of patients who they knew had specific needs. | |

**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) | 95.8% | 93.7% | 93.5% | No statistical variation |

|  | Y/N/Partial |
|---|---|
| Interpretation services were available for patients who did not have English as a first language. | Y |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | Y |
| Information about support groups was available on the practice website. | Partial |
| Explanation of any answers and additional evidence:<br>• Some information was available on the provider's website about mental health support services. The provider told us that a new website was being built and would be available in the near future. | |

| Carers | Narrative |
|---|---|
| Percentage and number of carers identified. | 544 Carers or 7.2 % of the patient population. |
| How the practice supported | A member of staff was designated as a carers champion. |

| carers (including young carers). | A notice board for carers was located in the waiting area. Staff kept carers up to date on what was happening to support carers in the area. Staff from the local Carers centre were scheduled to have a meeting with the carers champion and to provide training to staff. A carers coffee morning was planned. Carers were offered help with obtaining an appointment and flexibility to accommodate their needs. Carers were signposted to support services. |
|---|---|
| How the practice supported recently bereaved patients. | Patients were contacted by the practice and bereavement cards were sent. Patients were signposted to bereavement support services. |

**Privacy and dignity**

## The practice respected patients' privacy and dignity.

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

# Responsive                    Rating: Good

**Responding to and meeting people's needs**

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

| | Y/N/Partial |
|---|:---:|
| The practice understood the needs of its local population and had developed services in response to those needs. | Y |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided. | Y |
| The facilities and premises were appropriate for the services being delivered. | Y |
| The practice made reasonable adjustments when patients found it hard to access services. | Y |
| There were arrangements in place for people who need translation services. | Y |
| The practice complied with the Accessible Information Standard. | Y |
| Explanation of any answers and additional evidence: | |

| Practice Opening Times | |
|---|---|
| **Day** | **Time** |
| Opening times: | |
| Monday | 8am to 6.30pm |
| Tuesday | 8am to 6.30pm |
| Wednesday | 8am to 6.30pm |
| Thursday | 8am to 6.30pm |
| Friday | 8am to 6.30pm |
| Extended access was provided every week until 8.30pm on alternate Mondays or Tuesdays. | |
| Patients could access GPs seven days per week as from 01/10/2018 as part of the local Clinical Commissioning Group wide extended hours service. This was available from 5pm to 8pm Monday to Friday and 9am to 1pm Saturdays and Sundays. | |

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|---|---|---|---|---|
| 7472 | 271 | 117 | 43.2% | 1.57% |

| 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) | 96.6% | 94.8% | 94.8% | No statistical variation |

**Any additional evidence or comments**

## Older people                                      Population group rating: Good

**Findings**

- 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.
- There was a medicines delivery service for housebound patients.

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

**Findings**

- Patients with several long-term conditions were offered a single, longer appointment to avoid multiple visits to the surgery.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

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

**Findings**

- 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.
- Babies and young children were offered an appointment as a priority and appointments were available outside of school hours.

- The premises were suitable for children and babies and baby changing facilities were available.

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

### Population group rating: Good

**Findings**

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

- The practice was open until 8.30pm one evening per week and patients were encouraged to utilise the CCG wide extended hours provision.

- The practice was proactive in offering online services including the booking of appointments and requests for repeat prescriptions.

- Electronic prescribing was also provided.

- The practice provided on line consultations, triage and telephone consultations.

## People whose circumstances make them vulnerable

### Population group rating: Good

**Findings**

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers.

- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.

- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

- Same day appointments could be provided for patients whose circumstances made them vulnerable and longer appointments were available for patients with enhanced needs.

- Reasonable adjustments had been made to ensure patients' needs were met.

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

### Population group rating: Good

**Findings**

- The practice identified patients who experienced poor mental health in order to be responsive to their needs, for example by the provision of regular health checks.

- Priority appointments were allocated when necessary to those experiencing poor mental health.

- Patients experiencing poor mental health were referred to appropriate services such as psychiatry and counselling services and were informed about how to access various support groups and voluntary organisations.
- The practice had a lead nurse who saw many of the patients experiencing poor mental health. Feedback from these patients about the care and treatment they had received was very positive.

**Timely access to the service**

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

National GP Survey results

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

| 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) | 38.6% | N/A | 70.3% | Significant Variation (negative) |
| 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) | 52.9% | 65.5% | 68.6% | No statistical variation |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018) | 57.0% | 64.1% | 65.9% | No statistical variation |
| The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018) | 73.6% | 72.5% | 74.4% | No statistical variation |

| Any additional evidence or comments |
|---|
| The national patient survey results showed that the practice received lower than average scores about how easy it was to get through to someone at the practice on the phone (01/01/2018 to 31/03/2018). |

In response to patient feedback in this area the provider made several changes to increase the capacity of the clinical team and to the way in which patients book appointments. These changes included:

- The recruitment of additional GPs and advanced nurse practitioners.
- The provision of same-day appointments. All requests are triaged by a duty GP and allocated to the most appropriate clinician on the day. Almost all patients are seen on the same day, though clinicians have flexibility to book ahead if required.
- The provision of phone consultations when appropriate
- The provision of extended access.
- The introduction of E-Consult on line consultations
- The appointment system was flexible and allowed for a range of urgent and routine appointment and on-line appointments.

The provider regularly monitored demand and capacity and made changes to improve patient access in response.

**Listening and learning from concerns and complaints**

## Complaints were listened and responded to and used to improve the quality of care.

| Complaints | |
|---|---|
| Number of complaints received in the last year. | 23 |
| Number of complaints we examined. | 2 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 2 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | 0 |

| | Y/N/Partial |
|---|---|
| Information about how to complain was readily available. | Partial |
| There was evidence that complaints were used to drive continuous improvement. | Y |
| Explanation of any answers and additional evidence:<br><br>• A complaints policy and procedure was in place.<br><br>• A notice informing patients of the complaints procedure was on display in the waiting area.<br><br>• A complaints information leaflet was available to help patients understand the complaints procedure and how they could expect their complaint to be dealt with. This did not include information to inform patients that they could complain directly to NHS England if they so wished.<br><br>• We viewed a sample of two complaints and could see what the outcome of the investigation was and that there had been learning from complaints. | |

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|---|---|
| Patient received reminders for health checks when already booked appointment. | Reception team reminded to check if patient has made an appointment before sending reminder. |
| Patient appointment not booked in correctly. | Training arranged for member of staff in question. |

# Well-led                           Rating: Requires improvement

**Leadership capacity and capability**

## There was compassionate, inclusive and effective leadership.

|  | Y/N/Partial |
|---|---|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Y |
| They had identified the actions necessary to address these challenges. | Y |
| Staff reported that leaders were visible and approachable. | Y |
| There was a leadership development programme, including a succession plan. | Y |
| Explanation of any answers and additional evidence: | |

**Vision and strategy**

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

|  | Y/N/Partial |
|---|---|
| The practice had a clear vision and set of values that prioritised quality and sustainability. | Y |
| There was a realistic strategy to achieve their priorities. | Y |
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Y |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Y |
| Progress against delivery of the strategy was monitored. | Y |
| Explanation of any answers and additional evidence: | |

**Culture**

## The practice had a culture which drove good quality and 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 an 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 |
| When people were affected by things that went wrong they were given an apology and informed of any resulting action. | Y |
| The practice encouraged candour, openness and honesty. | Y |
| Explanation of any answers and additional evidence: <ul><li>Leaders and staff demonstrated a patient centred focus to their work during our discussions with them.</li><li>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.</li></ul> | |

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

| Source | Feedback |
|---|---|
| Discussions with members of the staff team | <ul><li>Staff told us they felt well supported and valued.</li><li>They told us there were positive relationships across the staff team.</li><li>Staff we spoke with demonstrated the values of openness.</li><li>Staff spoke about the person-centred care and treatment they provided to patients.</li></ul> |

**Governance arrangements**

## Governance arrangements were not always fully effective.

|  | Y/N/Partial |
|---|---|
| There were governance structures and systems which were regularly reviewed. | Partial |
| Staff were clear about their roles and responsibilities. | Partial |
| There were appropriate governance arrangements with third parties. | Y |
| Explanation of any answers and additional evidence:<br><br>There were areas where the governance systems had not been sufficiently effective to address shortfalls. These included:<br><ul><li>The system for reporting and managing significant events and incidents was not effective and we</li></ul> | |

saw examples whereby events had been repeated because they had not been dealt with appropriately following initial incidents. There was little evidence to show that a thorough investigation had taken place following events and that lessons learned had been shared across the staff team and used to drive improvement. There had been no periodic review of events to identify themes and trends.

- The system for managing patient safety alerts was not robust and failed to clearly demonstrate the actions taken in response to alerts.
- Formalised systems were not in place for mentoring non-clinical prescribers and checking their prescribing practices.
- Records were not always well maintained resulting in a lack of evidence to support some of the areas of work the provider told us about.

The provider told us they had recognised the shortfalls in the management of significant events and had started to attempt to address this. Following the inspection, the provider submitted documents to indicate that they were implementing new processes in response to our findings.

**Managing risks, issues and performance**

## The practice did not always 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. | Partial |
| There were processes to manage performance. | Partial |
| There was a systematic programme of clinical and internal audit. | Partial |
| There were effective arrangements for identifying, managing and mitigating risks. | Partial |
| A major incident plan was in place. | Y |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Y |
| Explanation of any answers and additional evidence:<br>The findings of the inspection showed that the provider's assurance systems and processes for managing risks were not always fully effective as detailed above under governance arrangements. | |

**Appropriate and accurate information**

## There was a commitment to using data and information proactively to drive and support decision making. However, the practice did not always act on information appropriately.

| | 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. | Partial |
| Explanation of any answers and additional evidence:<br>• Records were not always well maintained, and the provider could not evidence the effectiveness of some of their systems and processes for managing and mitigating risks as a result. | |

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

## The practice involved patients, staff and external partners to sustain good quality and sustainable care.

| | Y/N/Partial |
|---|---|
| Patient views were acted on to improve services and culture. | Y |
| The practice had an active Patient Participation Group. | Y |

| | |
|---|---|
| Staff views were reflected in the planning and delivery of services. | Y |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Y |
| Explanation of any answers and additional evidence:<br>• Improvements were made in response to feedback from patients and there was a clear drive to improve outcomes for patients. | |

Feedback from Patient Participation Group.

| Feedback |
|---|
| The practice had a Patient Participation Group (PPG). We met with two members of the PPG and they gave us positive feedback about the practice and felt that the provider listened to and acted upon the views of patients. |

## 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. | Partial |
| Explanation of any answers and additional evidence:<br><br>• The communication systems in place for sharing learning were not always fully effective. | |

| Examples of continuous learning and improvement |
|---|
| • The practice was involved in locality working to improve outcomes for patients. For example, the practice was involved in the Primary Care Network and the GP provider was the clinical lead for this.<br>• The provider told us they had plans for developing the services they provided. For example, the provision of dermatology services. The GP provider had an interest in dermatology and two GPs were undertaking a diploma in dermatology.<br>• The practice was looking to develop skype consultations for some areas of work. |

**Notes: CQC GP Insight**

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

| Variation 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.