

# Care Quality Commission

## Inspection Evidence Table

### Cottenham Surgery (1-2308461801)

Inspection date: 1 August 2019

Date of data download: 26 July 2019

## Overall rating: Good

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

## Safe Rating: Requires Improvement

We rated the provider as requires improvement for providing safe services because the practice did not always have clear systems and processes to keep patients safe:

- There were gaps in the provision of fire safety and the service had not assessed risks to the health and safety of service users and staff of providing the service and had not ensured the premises were safe for their intended purpose.
- The provider recently had carried out an internal infection prevention and control audit which had identified several areas for improvement including a lack of up to date infection control policy, gaps in the provision and suitability of staff training and a lack of protected time for the lead infection control nurse to carry out their responsibilities. Whilst the provider was aware of these issues, they had not been resolved at the time of our inspection.

### Safety systems and processes

**The practice systems, practices and processes to keep people safe and safeguarded from abuse were not always effective.**

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	n/a
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes

<b>Safeguarding</b>	<b>Y/N/Partial</b>
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes

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

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: December 2018	Yes
There was a record of equipment calibration. Date of last calibration: 8 August 2018	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: June 2019	Yes
There was a log of fire drills. Date of last drill: None recorded	No <sup>1</sup>
There was a record of fire alarm checks. Date of last check: 24 July 2019	Partial <sup>2</sup>
There was a record of fire training for staff. Date of last training: Annual	Yes
There were fire marshals.	No <sup>3</sup>
A fire risk assessment had been completed. Date of completion: 30 July 2019	Yes
Actions from fire risk assessment were identified and completed.	Partial <sup>4</sup>

Explanation of any answers and additional evidence:

<sup>1</sup>The service had not carried out any fire evacuation drills to test evacuation and response procedures in the event of a fire.

<sup>2</sup> The location did not have a fire alarm system installed. There were monthly emergency lighting and smoke detector checks carried out and the provider had plans in place to move to weekly checks.

<sup>3</sup>The provider had not identified and trained staff in the role of fire marshal to lead and coordinate fire emergency response arrangements.

<sup>4</sup> The practice had conducted an internal fire risk assessment which was completed 30 July 2019. There were a number of hazards identified; however, it was not always clear what, if any, action had been taken. For example, an electrical wiring inspection had been booked and more emergency signage ordered and installed. However, the risk assessment also identified hazards including a lack of internal fire doors which were self-closing, doors on escape routes which did not open in the direction of travel, and final exits that could not always be opened. None of these hazards had a record of any plan to reduce or eliminate the associated risks.

The provider had planned to carry out specific risk assessments for the evacuation of persons from the upstairs areas who may need to use the electric chair lift and planned to invite the local fire service to assist with the assessment, in September 2019.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: n/a	No
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: n/a	No
Explanation of any answers and additional evidence: The service had a health and safety policy in place which had not been reviewed since January 2017 and had not carried out any specific health and safety or premises and security risk assessment to ensure the safety of patients and staff and that the premises were safe for their intended purpose.	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: June 2019	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Partial
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence:	

The provider had carried out an internal infection control risk assessment and audit, identifying gaps including a lack of up to date infection control policy, gaps in the provision and suitability of staff training and a lack of protected time for the lead infection control nurse to carry out their responsibilities. The provider sought further assistance and advice from specialists within the clinical commissioning group and had arranged a visit the week following our inspection.

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes <sup>1</sup>
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
<p>Explanation of any answers and additional evidence:</p> <p><sup>1</sup>Staff told us there were often too few clinical appointments available which would sometimes impact on delivering timely care to patients. However, the practice were actively attempting to recruit new GPs and had in place agency and locum staff to fill gaps in staffing levels.</p> <p>The practice were also able to offer extended access appointments at other practices as part of a local federation and had introduced telephone consultations.</p>	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes

## Appropriate and safe use of medicines

### The practice 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) <small>(NHS Business Service Authority - NHSBSA)</small>	0.99	0.94	0.88	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2018 to 31/03/2019) <small>(NHSBSA)</small>	9.0%	11.3%	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) <small>(NHSBSA)</small>	6.57	5.86	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) <small>(NHSBSA)</small>	0.91	2.08	2.07	Variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about	Yes

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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes

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

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	Seven
Number of events that required action:	Seven

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Confidential waste was found in the recycling waste bin.	The practice responded by ensuring bins were clearly labelled and separated to prevent recurrence. The incident and actions taken were communicated to all staff and there were regular spot checks of the recycling waste.
Blood test recorded on the wrong	The patient's notes were amended, and both patients informed

patients records.	of the error. Staff were reminded of the importance of ensuring the correct patients' details were updated, especially where the patients were related or had the same names, by checking more than one piece of information.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: We saw examples of actions taken on recent alerts for example, regarding sodium valproate.	



## Effective

## Rating: Good

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) <small>(NHSBSA)</small>	0.25	0.82	0.77	Variation (positive)

## 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.
- The practice offered structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- NHS health checks were not offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## People with long-term conditions

## Population group rating: Good

### Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. The practice had not been able to provide NHS health checks due to staffing issues but planned to reintroduce these checks as part of regular healthcare assistant clinics.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring, however at the time of inspection the practice were awaiting computer software updates for their machines to be able to be used.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	76.2%	80.5%	78.8%	No statistical variation
Exception rate (number of exceptions).	11.3% (16)	15.7%	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)	78.9%	74.4%	77.7%	No statistical variation
Exception rate (number of exceptions).	9.9% (14)	11.9%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	81.3%	79.3%	80.1%	No statistical variation
Exception rate (number of exceptions).	21.1% (30)	15.5%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	91.3%	76.2%	76.0%	Significant Variation (positive)
Exception rate (number of exceptions).	5.9% (18)	7.9%	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>	97.4%	90.8%	89.7%	Tending towards variation (positive)
Exception rate (number of exceptions).	7.1% (6)	13.2%	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)	85.2%	82.2%	82.6%	No statistical variation
Exception rate (number of exceptions).	3.2% (15)	4.7%	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)	100.0%	90.8%	90.0%	Significant Variation (positive)
Exception rate (number of exceptions).	20.9% (14)	7.6%	6.7%	N/A

#### Any additional evidence or comments

The practice was aware of higher than local and national average exception reporting rates for some indicators and were addressing issues with clinical computer system coding and proactively engaging with a large transient population group. Records we reviewed demonstrated patients were appropriately exception reported.

## Families, children and young people

## Population group rating: Good

### Findings

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets in three out of four indicators. The practice population included approximately 1,000 patients from the Traveller community and had maintained a proactive commitment to facilitating care through a high level of engagement, including reducing barriers to accessing immunisations for this group which had previously contributed to lower than average performance in all indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- 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.
- 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.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

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)	33	40	82.5%	Below 90% minimum
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)	41	44	93.2%	Met 90% minimum
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)	40	44	90.9%	Met 90% minimum
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)	41	44	93.2%	Met 90% minimum

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>

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

Population group rating: Good

### Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The practice had not been able to provide NHS health checks due to staffing issues but planned to reintroduce these checks as part of regular healthcare assistant clinics. However, there was appropriate and timely follow-up on the outcome of health assessments and checks that were carried out where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical	72.1%	70.9%	71.7%	No statistical

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) (PHE)				variation
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	70.0%	73.4%	69.9%	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)	56.1%	56.9%	54.4%	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)	68.0%	63.0%	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)	57.9%	60.6%	51.9%	No statistical variation

#### Any additional evidence or comments

Practice uptake rates for the cervical cancer screening programme were in line with local and national averages; however, rates were below the 80% national target. The practice had appropriately trained staff, an effective call and recall process, offered appointments at a variety of times and were proactive in engaging with eligible patients, including in the local Traveller community, to raise awareness of the screening programme and promote higher uptake.

#### People whose circumstances make them vulnerable

#### Population group rating: Good

#### Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which considered 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.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.
- The practice was proactive in identifying and addressing healthcare inequalities for the local traveller community, which made up a significant proportion of the overall patient list. The practice provided flexible appointments for this group and engaged directly with the community to promote healthcare. The practice were also involved in published research studies into vaccination uptake in traveller communities which contributed to national research and government committee

reviews, findings and recommended actions aimed at addressing health and social inequalities.

**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 appropriate health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

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) <small>(QOF)</small>	100.0%	91.0%	89.5%	Tending towards variation (positive)
Exception rate (number of exceptions).	8.3% (1)	13.2%	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) <small>(QOF)</small>	100.0%	89.7%	90.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	8.3% (1)	11.8%	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) <small>(QOF)</small>	88.5%	85.0%	83.0%	No statistical variation
Exception rate (number of exceptions).	3.7% (1)	6.6%	6.6%	N/A



## Monitoring care and treatment

The practice had a programme of quality improvement activity and reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	552.0	543.0	537.5
Overall QOF score (as a percentage of maximum)	98.7%	97.1%	96.2%
Overall QOF exception reporting (all domains)	6.2%	6.5%	5.8%

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

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

- The practice monitored compliance with local clinical commissioning group guidelines for the provision of direct oral anticoagulant medicines (DOACs). The audit identified that of 50 patients, 12 were being recalled for testing more frequently than guidelines recommended. The audit also identified seven patients had missing information required for effective recall rate setting and no patient records had it documented they were asked monitoring questions in line with guidelines. The practice discussed the findings, updated their call and recall monitoring system including a proforma for recording patient discussions into the patient record. In the second audit cycle, the practice saw the levels of information in each patient's records increase, including recording of monitoring questions. However, the recall frequency rate remained higher than guidelines which the practice were monitoring through additional audit cycles.



## 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.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes

## Coordinating care and treatment

**Staff worked together and with other organisations to deliver effective care and treatment.**

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

## Helping patients to live healthier lives

### The service was not always proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Partial <sup>1</sup>
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
Explanation of any answers and additional evidence: <sup>1</sup> The practice had not been able to provide NHS health checks due to staffing issues but planned to reintroduce these checks as part of regular healthcare assistant clinics. However, there was appropriate and timely follow-up on the outcome of health assessments and checks that were carried out where abnormalities or risk factors were identified.	

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>	97.7%	95.3%	95.1%	No statistical variation
Exception rate (number of exceptions).	1.4% (11)	0.9%	0.8%	N/A

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	n/a

## Well-led

**Rating: Good**

### Leadership capacity and capability

**Leaders 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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes

### Vision and strategy

**The practice did not have a 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.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial <sup>1</sup>
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial <sup>1</sup>
Progress against delivery of the strategy was monitored.	Yes
<sup>1</sup> The practice did not have a specific formalised set of values, a vision or a mission statement; however, staff and leaders demonstrated a commitment to providing patient focussed care.	

## Culture

### The practice had a culture which supported high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes

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

Source	Feedback
Staff interviews	Staff were happy working in the practice, felt supported by leaders and felt valued. Staff told us they were listened to and encouraged and supported to make changes and were a part of the practice development.

## 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.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:	
Governance systems were not always effective in identifying and managing practice policies, procedures, risk assessments and plans which were overdue for review or not reflective of current practice and had not been used or were not effective for a period between 2017 and 2019.	

## Managing risks, issues and performance

### Processes for managing risks, issues and performance were not always effective.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Partial
Staff were trained in preparation for major incidents.	Partial
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial
Explanation of any answers and additional evidence:	
Practice records showed that assurance systems were not always effective for a period between 2017 and 2019 until an interim practice manager was appointed. The interim practice manager had reviewed, updated and reinstated assurance systems; however, these systems were not complete and required further action. For example, the practice had not carried out health and safety or premises and security risk assessments, fire risk assessment actions were not completed, and the practice business continuity plan was out of date.	

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

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

**The practice did not always involve 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.	Partial <sup>1</sup>
The practice had an active Patient Participation Group.	No <sup>2</sup>
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence:	
<sup>1</sup> The practice did not have an active patient participation group however did review patient feedback and complaints to inform changes and make improvements.	
<sup>2</sup> The practice did not record or review verbal or informal feedback from patients.	

## Continuous improvement and innovation

**The practice had systems and processes for learning, continuous improvement and innovation.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes <sup>1</sup>
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	
<sup>1</sup> There was a programme of learning and development for staff which the practice supported, including internal and external learning events. However, during our inspection staff told us that they had not always had protected time to perform non-patient facing duties and that this was beginning to change with more time being made available specifically for non-patient facing duties.	

## Examples of continuous learning and improvement

The practice was a teaching practice and actively engaged medical students in general practice and primary care through audits, learning events and supporting their learning needs. The practice had been awarded two teaching awards.

## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.