

Care Quality Commission

Inspection Evidence Table

The Cambridge Practice (1-5522693627)

Inspection date: 31 July 2019

Date of data download: 19 July 2019

Overall rating: Requires improvement

We rated the practice as requires improvement overall because:

There were gaps in documentation of staff recruitment files and some governance processes required a review to ensure they were applied consistently.

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

Safe

Rating: Requires improvement

We rated the practice as requires improvement for Safe because:

There were systems in place to keep patients safe, but some areas required a review. For example, staff training to the appropriate level for safeguarding, disclosure and barring service checks for clinical staff and ensuring staff recruitment checks were carried out in line with guidance. In addition, high risk actions arising from risk assessments required embedding.

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse, although some areas required a review.

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 (a)
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	N (b)
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y (c)
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	N (d)

Safeguarding	Y/N/Partial
Staff who acted as chaperones were trained for their role.	Y (e)
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
<p>Explanation of any answers and additional evidence:</p> <p>(a) The practice policies were available to staff on the practice computer system. The programme used had been newly implemented into the practice software systems and many staff were familiar with how to access the policies. Help and ongoing support was available for any member of staff who was having difficulty accessing the policies. We noted the safeguarding policy did not contain information on how to access external services if a safeguarding incident required escalating. The practice told us they had decided not to make changes directly to the online policy and had added an appendix with the appropriate details of external contacts. All the clinical and treatment rooms had a print out of the local safeguarding teams and contact details for staff to refer to.</p> <p>(b) Staff training for safeguarding had been completed for all staff. The non-clinical staff had been trained to level one for child safeguarding. The practice was unaware of the new levels of training recommended in the intercollegiate guidance for child safeguarding published in January 2019.</p> <p>(c) The practice told us they did not routinely share safeguarding information with the out of hours (OOH) service. The OOH service could access the practice records and would be able to see alerts and flags on the system if a patient had a safeguarding concern.</p> <p>(d) We reviewed a sample of staff recruitment files and found two clinical staff did not have a DBS check.</p> <p>(e) All staff who acted as chaperones had been trained for the role. The practice had applied for all the non-clinical staff to receive DBS checks and until these were received, only clinical staff could act as a chaperone. Non-clinical staff we spoke with on the day were aware of this limitation and told us they would not act as chaperones until they had been DBS checked.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N (f)
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N (g)
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <p>(f) We viewed five staff recruitment files (for staff recruited since the merger) and found there were two clinical staff who had not received a DBS check. One member of clinical staff who worked on a locum basis had not had their qualifications checked and there was no proof of their identity in their file. None of the five staff files contained any information about the health status of staff, to identify if the practice needed to make any reasonable adjustments to enable them to carry out their role.</p> <p>(g) The practice had not received or recorded the vaccination and immunity status for staff who come into contact with patients, to identify if there were any vaccination requirements. The practice told us they would review this arrangement after the inspection.</p>	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: July 2019 (both sites)	Y
There was a record of equipment calibration. Date of last calibration: October 2018 (both sites)	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	N (h)
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: May 2019 (main site) September 2018 (branch site)	Y
There was a log of fire drills. Date of last drill: July 2019 (both sites)	Y
There was a record of fire alarm checks. Date of last check: July 2019 (both sites undertook weekly checks)	Y
There was a record of fire training for staff. Date of last training: Various dates (online training)	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: July 2019 (both sites)	Y
Actions from fire risk assessment were identified and completed.	Partial (i)
<p>Explanation of any answers and additional evidence:</p> <p>(h) At the main site the practice told us the hospital provider undertook all the risk assessments for COSHH and cleaning products, and a team of cleaners employed by the hospital did all the cleaning within the building. This included any spillages of body fluids. There were COSHH risk assessments and information at the branch site.</p> <p>(i) Fire risk assessments for both sites had been undertaken in July 2019. We noted some high risk concerns requiring action had been instigated, such as training additional staff to become fire wardens. After the inspection the practice sent us their action plans with timescales for completing the remaining high and medium risk actions.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: July 2019 (both sites)	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: July 2019 (both sites)	Partial (j)
<p>Explanation of any answers and additional evidence:</p> <p>(j) Health and safety risk assessments for both sites had been undertaken in July 2019. We noted some high risk concerns requiring action had been instigated, such as removing extension leads which were being used unsafely. After the inspection the practice sent us their action plans with timescales for completing the high risk actions.</p> <p>We were also shown legionella risk assessments for both sites and saw evidence of preventative measures such as regular water temperature checking and flushing water outlets.</p>	

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. Date of last infection prevention and control audit:	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
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

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

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)	0.93	0.86	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) (NHSBSA)	9.0%	9.1%	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)	6.05	5.63	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)	2.10	1.88	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.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
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
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

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	14
Number of events that required action:	14
Explanation of any answers and additional evidence: The practice had a log of the recorded significant events from January 2018 to July 2019. We reviewed ones relating to the time since the provider had registered with the CQC (July 2018). The practice proactively reported significant events externally and were the highest reporter (44%) of National Reporting and Learning System (NRLS) concerns across the clinical commissioning group. We saw a spreadsheet detailing 31 incidents reported through NRLS between July 2018 and July 2019.	

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

Event	Specific action taken
Spillage of body fluids during procedure.	Staff training to ensure safe technique used.
Patient paperwork had not been suitably processed.	Process reviewed by manager and staff supported to undertake training.
A patient emergency in the waiting room following administration of vaccines.	Protocol for vaccination reviewed and new policy implemented to ensure patients wait for 20 minutes after receiving injectable vaccines.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: 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 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 (k)
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
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
<p>Explanation of any answers and additional evidence:</p> <p>(k) We were shown practice data relating to the number of patients who were on repeat medications and had received a medication review in the preceding 12 months;</p> <ul style="list-style-type: none"> 70% of patients on one or more medications had received a medication review. 79% of patients on four or more medications had received a medication review. <p>The practice had recruited a clinical pharmacist who undertook medication reviews for patients. They also visited patients in their place of residence if they were unable to attend the practice for their review. There was a system in place for staff to alert the pharmacist when a medication review was required.</p>	

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>	1.54	0.85	0.77	Tending towards variation (negative)
<p>Explanation of any answers and additional evidence:</p> <p>The practice was aware of their higher than average prescribing of hypnotics and had discussed this during a clinical meeting to raise awareness.</p>				

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 carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were 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.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- 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) <small>(QOF)</small>	82.9%	80.9%	78.8%	No statistical variation
Exception rate (number of exceptions).	15.4% (122)	9.2%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	81.8%	79.3%	77.7%	No statistical variation
Exception rate (number of exceptions).	7.1% (56)	7.8%	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>	81.6%	83.3%	80.1%	No statistical variation
Exception rate (number of exceptions).	11.2% (89)	10.8%	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>	74.7%	73.2%	76.0%	No statistical variation
Exception rate (number of exceptions).	1.4% (11)	4.0%	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>	90.7%	92.2%	89.7%	No statistical variation
Exception rate (number of exceptions).	8.2% (29)	10.3%	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) <small>(QOF)</small>	82.2%	81.5%	82.6%	No statistical variation
Exception rate (number of exceptions).	2.3% (54)	3.1%	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) <small>(QOF)</small>	97.0%	93.7%	90.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	3.4% (7)	5.9%	6.7%	N/A

Families, children and young people

Population group rating: Good

Findings

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets.
- 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)	203	251	80.9%	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)	186	240	77.5%	Below 80% uptake
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)	185	240	77.1%	Below 80% uptake
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)	186	240	77.5%	Below 80% uptake

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

There was a system in place to follow up on children who did not attend for vaccination. The practice had regular contact with the local health visiting team and could contact them if they had any concerns about a child or family.

The practice showed us their unverified figures for childhood immunisations for the period April 2019 to June 2019. The data demonstrated the practice had achieved the 90% minimum target for childhood immunisations. The immunisations uptake for children aged two had achieved 93% which was only 2% below the world health organisation (WHO) target of 95%.

The practice had also identified the immunisation data for the preceding year (2018/19) had not all been submitted. Therefore, the uptake rates for immunisations had been under reported. The practice was in the process of resubmitting their immunisation data which would improve the uptake rates previously reported.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) <small>(Public Health England)</small>	76.6%	75.6%	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) <small>(PHE)</small>	73.5%	73.1%	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) <small>(PHE)</small>	56.5%	62.2%	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) <small>(PHE)</small>	86.3%	77.0%	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) <small>(PHE)</small>	43.5%	43.5%	51.9%	No statistical variation

Any additional evidence or comments

Although the practice had achieved a higher uptake of cervical screening than the local and national averages, they were still below the 80% target set by NHS England. The practice showed us their unverified quality and outcomes framework data which showed the practice had achieved an 81% uptake of cervical screening in 2018/19.

The nursing team understood the challenges facing the practice to increase uptake rates for eligible women requiring cervical cytology screening. Nurses who undertook the screening had all been trained and attended updates 3-yearly. Samples sent were checked to ensure a result was received and patients who did not attend were followed up by the nursing team. There were no set cervical screening clinics which enabled patients to book appointments at any time, including during extended hours.

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. According to the practice own unverified data, the uptake of health checks for patients with a learning disability in 2018/19 was 60%.
- The practice had easy read leaflets and information for patients and was a registered learning disability friendly practice.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice 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, where necessary.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- 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.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months. The practice was registered as a dementia friendly practice.
- 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%	91.8%	89.5%	Significant Variation (positive)
Exception rate (number of exceptions).	3.8% (3)	10.8%	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>	92.1%	89.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	2.6% (2)	9.0%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	73.8%	83.3%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.8% (3)	4.9%	6.6%	N/A

Any additional evidence or comments

We were shown the practice unverified data for 2018/19 which demonstrated an increase in reviews of patients with dementia to 80% (an increase from 74% in 2017/18). This was in line with the local and national averages and had enabled the practice to achieve the target required to achieve 100% score for this group of patients.

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	559.0	547.6	537.5
Overall QOF score (as a percentage of maximum)	100.0%	98.0%	96.2%
Overall QOF exception reporting (all domains)	4.5%	4.4%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
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

Acne audit

An audit of patients being treated for acne was carried out in February 2019. The purpose was to determine if patients were receiving appropriate prescribed medications (oral and topical) and if the prescribing clinicians were following the latest guidance. The guidance recommended an oral antibiotic for no longer than 3 months duration with a concurrent topical treatment, which could continue after the antibiotic course had finished. A topical antibiotic was not recommended.

The first audit cycle (February 2019) identified 39 patients who met the criteria, of whom only 8% had a concurrent prescription for a topical treatment. 74% had not been prescribed a topical antibiotic, in line with guidance.

Treatment of acne was reviewed and discussed at a clinical meeting. Patients who were identified as being on oral antibiotic treatment for longer than the recommended duration (3 months) were invited for a review. Patients who had not requested a repeat prescription of their oral antibiotic in the preceding 12 months had their prescription removed from the repeat. The use of topical treatments and best practice guidance was also discussed.

The second audit cycle (April 2019) identified 29 patients who met the criteria, of whom 14% had a concurrent prescription for a topical treatment. 76% had not been prescribed a topical antibiotic.

Additional learning included adding the topical treatment to the label for the antibiotic to advise to be taken concurrently, to offer six weeks prescription of antibiotic initially and review use, and to consider a dermatology referral after taking 2 courses of antibiotic (with minimal or no reduction in symptoms).

Opioids audit

A CCG initiated audit of opioid prescribing led to a review of patients taking high potency medicines, such as morphine. (Opioids are a group of medicines that are used for pain relief and require monitoring and review to prevent misuse, abuse or addiction).

The practice identified 60 patients to include in the audit and sent them a letter informing of the need to review their medication and the risks that taking these medicines over a prolonged period could raise. During the review process, the practice identified some prescriptions being offered for longer than a month at a time (which was not in line with legislation) and initiated a structured approach to offering prescriptions to patients who mismanaged their requests. Some patients were referred to an external organisation as their care needs would be better met with another service. The practice also commenced repeat prescribing by the patients named GP to offer better oversight and monitoring. Following the review and implemented actions, the practice had achieved a 68% of patients who had either reduced or stopped their opioid medication.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles. Appraisals for non-clinical staff were not yet being undertaken.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial (I)
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>(I) The practice manager had held one-to-one meetings with the non-clinical staff as they were aware there had not been a process of formal appraisals taking place since the formation of the new provider. As a result of the informal one-to-ones a number of staff were identified to undertake new or additional roles to compliment and add to the practice skill mix.</p> <p>There were plans to hold formal appraisals for non-clinical staff. We saw evidence of appraisal for clinical staff.</p>	

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

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

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	94.6%	94.4%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.3% (9)	0.5%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	N (m)
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence: (m) We were told consent was gained in accordance with guidance although there was no formal process for monitoring consent seeking processes. The practice told us they would review this arrangement after the inspection.	

Caring

Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
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

CQC comments cards	
Total comments cards received.	19
Number of CQC comments received which were positive about the service.	14
Number of comments cards received which were mixed about the service.	5
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comment cards	<ul style="list-style-type: none"> • Staff were friendly and helpful. • Wonderful staff who go the extra mile to help. • Excellent service and lovely staff. • Not always able to get an appointment when needed. Can be over 2 weeks to see a GP. • Waiting times (for appointments) can be long.
Patient interviews	<ul style="list-style-type: none"> • Merger did not impact on care received. • Happy with surgery and GPs. • All staff were polite and professional. • Some difficulties accessing appointments when needed. • Staff were helpful and caring.

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
22,687	282	95	33.7%	0.42%

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 (01/01/2019 to 31/03/2019)	86.1%	90.2%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	84.3%	89.5%	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 (01/01/2019 to 31/03/2019)	96.4%	96.0%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	86.0%	85.1%	82.9%	No statistical variation

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

Any additional evidence
<p>The practice had used technology to support gaining patient feedback. They used the friends and family test via text messaging to gain patient views. There were also paper feedback forms in the waiting rooms of both practice sites.</p> <p>One of the GPs had also collected feedback from patients who had minor surgery. We were shown the results which indicated a high level of satisfaction overall and positive feedback about communication.</p>

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

Source	Feedback
Interviews with patients.	We spoke with five patients during the inspection day. They told us they felt involved in their care and treatment and had the opportunity to ask questions. Most patients had their medication explained to them.

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 (01/01/2019 to 31/03/2019)	96.9%	94.8%	93.4%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y (n)
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
<p>Explanation of any answers and additional evidence:</p> <p>(n) We were told that on some occasions a patient relative or friend would be asked to interpret for a patient. The practice also employed staff who could speak different languages and was able to utilise some of these staff for translation, where necessary.</p> <p>The practice had identified some cultural differences within the local population which made use of some interpretation services difficult. They were reviewing how they could work with the local population to overcome these barriers.</p>	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 527 patients as a carer on the carers register. This represented 2% of the practice population.
How the practice supported carers (including young carers).	Posters and other information in the practice waiting rooms promoted identification of carers and new patients were asked if they were a carer on the practice registration form. Once identified, carers were signposted to external sources of help and support and offered a health check. The practice could also access support for carers through a local integrated care team. Home visiting paramedics with concerns about a carer could raise this with the practice for additional support.
How the practice supported recently bereaved patients.	The practice sent a sympathy card from the named GP for the patient. GPs would also undertake a call or visit to the family where appropriate.

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

Responsive

Rating: Good

The practice organised and delivered services to meet patients' needs/ Services did not 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

Practice Opening Times	
Day	Time
Opening times:	
Monday to Friday	8am to 6.30pm
Appointments available:	
Monday to Friday	Am: 8am to 12.40pm Pm: 1.40pm to 6.30pm
Extended Hours:	
The practice offered extended hours on Monday or Wednesday evenings from 6.30pm to 8pm, Tuesday and Thursday mornings from 7.30am to 8am and the second and fifth Saturdays of the month from 8.45am to 11.45am.	
Federation extended hours:	
The practice was part of a federation of GP services. The federation offered extended hours appointments from 6.30pm to 8pm Monday to Friday and 8.30am to 12pm on Saturdays. Patients from The Cambridge Practice could access these appointments via their own surgery.	

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
22,687	282	95	33.7%	0.42%

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 (01/01/2019 to 31/03/2019)	95.8%	95.4%	94.5%	No statistical variation

Older people

Population group rating: **Good**

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- The practice could access external organisations to help support the social needs of older patients. They were due to commence a social prescribing service which would further benefit the older population.

People with long-term conditions

Population group rating: **Good**

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- 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.
- The practice ran dedicated “flu” clinics on four Saturdays at the beginning of flu season. Patients who were unable to access the surgery were visited at their place of residence and offered the flu vaccination there.
- Patients with long term conditions could access a talking therapy service to help them manage and adapt to their condition.

Families, children and young people

Population group rating: Good

Findings

- Additional nurse appointments were available outside of the practice core hours, for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Staff could refer young patients in crisis to a safe haven service and youth counselling services.

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 offered appointments outside their core opening hours. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and 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. This included visiting patients in their place of residence if they were unable to attend the practice to undertake health checks and if unwell.
- The practice was aware of a variety of external organisations and volunteer groups to help and support vulnerable patients. They were also due to commence social prescribing service which would offer further benefit to vulnerable patients.

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

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly, including support organisations for young patients.
- Before the merger, staff from the individual practices had attended a mental health workshop organised by an external stakeholder, where patients, healthcare professionals and volunteers had discussed and reviewed any challenges or access barriers for patients experiencing mental health conditions. As a result of the consultation and shared ideas, the practice had introduced a bag of “fiddle toys” and emotion cards in each clinical room. The toys could be used to distract patients with mental health conditions and patients who found it difficult to communicate could use the cards to express how they were feeling.
- In addition, the practice had commenced a red wristband system to identify patients waiting in the waiting room. When the reception team saw a patient with a red wristband, they would take them to a quiet room and offer them a drink whilst they waited to be seen. This enabled patients to wait in a calm environment until they were seen. The GPs would be alerted to the patient’s arrival and make the necessary arrangements to see them as soon as possible and minimise the waiting time.

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 (01/01/2019 to 31/03/2019)	63.2%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to	67.3%	68.7%	67.4%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
the overall experience of making an appointment (01/01/2019 to 31/03/2019)				
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	59.5%	63.2%	64.7%	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 (01/01/2019 to 31/03/2019)	79.5%	75.3%	73.6%	No statistical variation

Source	Feedback
NHS Choices	<p>We reviewed feedback left on the NHS site for the practice. There had been five items of feedback. Two of these were positive and three were negative.</p> <p>The positive comments reflected the opportunity to have more choice for accessing care now the two GP practices had merged.</p> <p>The negative comments related to difficulties accessing appointments (including using online booking systems), staff attitude, lack of appropriate care for complex care needs and being offered an inappropriate appointment.</p>
Comment cards	There was mixed feedback from patients about appointment access and waiting times. Some patients told us they could access appointments when they needed to, and others told us they had difficulty accessing the service and making suitable appointments.
Patient interviews	<p>Of the five patients we interviewed, two reported no concerns with accessing appointments. The remaining three stated they could not always access appointments at a time suitable for them.</p> <p>Two patients also told us there was a wait of up to four weeks to see a GP of their choice.</p>
Friends and family test	The practice showed us their friends and family data for May 2019 to July 2019. The satisfaction scores and recommendations of patients was consistently above 90% for all three months.

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.	Unknown (o)
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4

Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0
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	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <p>(o) The practice manager had been in post for approximately eight weeks at the time of the inspection. They had been unable to identify how many complaints had been received and reviewed by the practice prior to their arrival. One of the GPs was the lead for complaints and had been handling these prior to the new practice manager being in post. We reviewed four complaints and found they had all been effectively handled in an appropriate timescale. One of the complaints responses did not include the health ombudsman in the letter and we were told a complaints information leaflet was sent with the letter, which did include the health ombudsman.</p> <p>The practice had a complaints policy which outlined how to handle complaints and how they should be recorded and retained. We found not all the systems described in the policy were reflected in the practice systems. For example, there was no complaints register to detail dates, times and management of all complaints. There was also no record of verbal complaints or verbal feedback. The practice commenced a complaints log after the inspection, for complaints received in July 2019. They also told us they would review how they documented verbal feedback if it was not deemed a formal complaint requiring escalation through the complaints process.</p> <p>We did see one example where a verbal complaint was dealt with and followed up in writing to the patient. This had been included in the new complaints register that was sent to us after the inspection.</p> <p>We were shown a presentation on effective complaints management which had been presented to non-clinical staff by the new practice manager. The presentation was used alongside the introduction of the new complaints policy which had come into effect in July 2019.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
A repeat prescription did not contain all the items requested.	Staff were reminded to check medication requests carefully to ensure all the medicines requested were added to the patient record.
A patient was advised to attend another healthcare facility when they arrived at the practice with an urgent problem.	Staff were reminded of the practice contractual obligation to see, assess and treat patients who arrive without an appointment and are in need of priority care. In the event the patient was still required to attend another healthcare facility, staff were to review the transportation needs of the patient and arrange appropriate transfer.
A patient complained about the attitude of a GP during a consultation.	The GP reflected on the care and treatment offered and identified some learning and change in practice. The learning was due to be shared with the wider clinical team at the next clinical team meeting in September 2019.

Well-led

Rating: Requires improvement

We rated the practice as requires improvement for well led because:

Governance processes for complaints management, risk assessments and monitoring consent required a review.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	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: The new practice manager had implemented many changes in process and introduced new policies into the practice since they started in June 2019. They had already identified areas of weakness and had developed an action plan to address these. They had also held discussions with staff and identified under-utilised skills and abilities. Staff told us the changes had been positive and made a difference to them and their patients.	

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.	P (p)
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: (p) We spoke with a variety of clinical and non-clinical staff during the inspection day. Not all the staff were aware of the practice vision or values.	

Culture

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

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

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

Source	Feedback
Staff interviews	Staff told us they enjoyed working at the practice and there were positive relationships between teams and managers/leaders.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. However, complaints management required a review.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	P (q)
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: (q) The governance arrangements for recording and retaining oversight of complaints was not effective. The practice could not establish how many complaints had been received since the formation of the new provider in April 2018. This was not in line with the practice policy for complaints record keeping. After the inspection, the provider sent us a new complaints log.	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance. However, some areas required a review.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	P (r)
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	P (s)
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: (r) Non-clinical staff had not received an appraisal (where applicable) and the practice manager had held individual conversations to identify staff skills and roles. Appraisal is an effective way of monitoring and managing performance of individuals. (s) There was no oversight of consent seeking processes to ensure patient safety and review the effectiveness of consent management.	

Appropriate and accurate information

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

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

Engagement with patients, the public, staff and external partners

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

and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
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

Feedback from Patient Participation Group (PPG).

Feedback

We spoke with one member of the PPG who told us they worked closely with the practice to understand the challenges such as, appointments, complaints and the results of the national GP patient survey. They were encouraged to make suggestions to the service on how they could improve and felt they were listened to by the practice.

Any additional evidence

The practice told us the PPG had been actively involved in the planning for the merger between the two practices and had selected the name of the new practice from a short list of 10 proposed by the joint practice staff.

Since the merger, the PPG meetings had become less frequent and attendance had reduced. The practice manager told us they had a plan for improving this and was inviting the PPG to a meeting in September 2019 to discuss this.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

Examples of continuous learning and improvement

The practice manager had identified several areas of practice requiring a review and had produced action plans to address these. They had also introduced new policies and processes.

Staff told us they had accepted the proposed changes and were working together to enable the new systems to be embedded. Staff had been involved in planning the merged services and continued to be involved in all areas of service delivery.

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.