

Care Quality Commission

Inspection Evidence Table

Mirfield Surgery - Sahay (1-544068059)

Inspection date: 5 August 2019

Date of data download: 25 June 2019

Overall rating: Good.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/1

Effective

Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	N/A
<p>Explanation of any answers and additional evidence:</p> <p>Clinical staff explained they had access and referred to the British National Formulary (BNF), attended clinical meetings, and completed their requirement of 50 hours of Continual Professional Development (CPD) meetings as well as completing the one hot topic full day course (a wide range of courses on various topics aimed at supporting continuous professional development).</p> <p>The clinical team had an electronic communication application which provided GPs with a platform to share updates as well information regarding cover required in a timely manner.</p> <p>The practice operated a query board which was located on the clinical system. Staff explained GPs reviewed the query board at the end of each clinical session and took appropriate actions where relevant.</p> <p>Staff demonstrated awareness of their Hypnotics prescribing which showed negative variation from the local and national averages. Staff explained the practice faced challenges regarding patients prescribed controlled drugs and Hypnotics who were managed by the community mental health teams. The leadership team explained historically Hypnotic prescribing had decreased; however, due to the influx of new patients following the closure of neighbouring practices prescribing had increased. Staff explained this was mainly due to patients who registered following the closure of neighbouring practices who had no history of a medicine review, patients were prescribed multiple controlled drugs as well as Hypnotics. To address this the practice implemented a policy and developed an associated information</p>	

letter which advised patients that clinicians would only prescribe Hypnotics as a short course and medicines would not be added to repeat prescriptions. Staff also explained that meetings were held with the community mental health teams and patients were provided with sleep diaries as well as information to improve sleep hygiene. Patients were also signposted to Healthy Minds clinics which were available within the practice.

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>	1.77	0.75	0.77	Variation (negative)

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. (practice discussed a clear process)
- 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 suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- 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>	74.9%	80.0%	78.8%	No statistical variation
Exception rate (number of exceptions).	10.6% (34)	12.4%	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>	70.9%	77.3%	77.7%	No statistical variation
Exception rate (number of exceptions).	5.9% (19)	10.3%	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>	79.7%	81.1%	80.1%	No statistical variation
Exception rate (number of exceptions).	6.2% (20)	11.3%	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>	74.4%	76.6%	76.0%	No statistical variation
Exception rate (number of exceptions).	1.3% (5)	6.2%	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>	90.8%	91.3%	89.7%	No statistical variation
Exception rate (number of exceptions).	2.1% (3)	11.2%	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)	84.2%	83.1%	82.6%	No statistical variation
Exception rate (number of exceptions).	2.3% (14)	4.5%	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)	91.2%	88.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	10.5% (4)	8.3%	6.7%	N/A

Any additional evidence or comments

At the time of our inspection, the 2018/19 QOF data had been submitted; therefore, the practice did not have access to it and were awaiting the data to be returned ahead of publication.

Families, children and young people

Population group rating: Good

Findings

- Childhood immunisation uptake rates showed the practice mainly met the World Health Organisation (WHO) targets rates. With the exception of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) which was below 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)	73	79	92.4%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	95	104	91.3%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	92	104	88.5%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	94	104	90.4%	Met 90% minimum (no variation)

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

Any additional evidence or comments

The practice operated a call and recall system to enable effective follow up of children who did not receive their childhood immunisations. The practice received an influx of patients following the closure of neighbouring practices which staff explained had an impact on the uptake of childhood immunisations. To address this the practice sent letters as well as text messages and phone calls to parents and legal guardians encouraging them to present their children for vaccinations. October 2018 data provided by the practice showed 90% uptake for children aged two who received their immunisations and 87% of children aged four their booster.

Practice provided examples of letters which they sent to parents and guardians reminding them to present their child for their immunisation.

Working age people (including those recently retired and students)

Population group rating: **Good.**

Findings

- Data showed that the uptake of national screening as well as the number of two week wait referrals was below local and national averages. The practice demonstrated awareness of their data and were taking action to improve performance.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	65.2%	68.1%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	51.3%	63.8%	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)	34.6%	44.0%	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)	54.5%	74.1%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	16.7%	52.0%	51.9%	Tending towards variation (negative)

Any additional evidence or comments

National screening programmes:

To improve the uptake of breast cancer screening staff explained that they received lists from Mammogram service of patients who failed to attend their appointments. The practice then contacted identified patients to rearrange their appointments as well as discuss the benefits of having the test. Staff explained, the uptake of cervical screening has steadily increased over the past four years. For example, data provided by the practice showed the uptake of cervical screening had increased from 71% in 2015 to 76% in 2019 which is above local and national averages.

Staff explained that the practice received a list of patients who had been sent bowel screening kits but had not returned these for testing. The practice actively contacted these patients and added alerts to patient records to ensure discussions were carried out opportunistically at every possible opportunity. The practice explained that they were also in the process of implementing a system to enable the practice to send letters generated by the screening services using the practice letter head.

The practice operated a call and recall system for cervical screening. This included reception staff contacting identified patients and booking appointments. Staff explained up to three appointment letters were sent and clinical staff were carrying out screenings opportunistically. Early appointments were introduced for cervical screening from 7am as well as late appointments after 4pm to offer flexibility for patients who were unable to attend during normal surgery hours. The practice offered additional appointments as part of an extended access Hub arrangement. Pre-bookable appointments were available between 6.30pm and 8pm Monday to Friday as well Saturday mornings. The practice encouraged patients to sign up for online access; data provided by the practice showed 20% of patients were registered for online access.

Two Week Wait (TWW) referrals:

The practice demonstrated awareness of their referral rates and explained a small number of new cancer cases patients were identified as a result of a TWW referral; staff explained more referrals were being carried out and at the time of our inspection were exploring systems to enable the practice to measure the number of referrals made. Following our inspection, the practice carried out a search of their clinical system which showed they had made 240 TWW referrals (10 per month) in the last two years.

Exception reporting:

2017/18 QOF exception reporting for Cancer was 45%, compared to local average of 24%, and national average of 26%. Staff explained the percentage represented patients who were automatically exception reported such as newly registered patients who were diagnosed at their previous practice. Data provided by the practice showed they had not manually exception reported any patients in 2017/18 or 2018/19 QOF year. Data provided during our inspection showed, exception reporting had declined to 28% for 2018/19 QOF year. Staff explained, exceptions had been made automatically within the clinical system and not by the practice.

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 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.

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

Population group rating: Requires improvement. This was because some Quality Outcome Framework indicators for patients in this population group was below local and national averages.

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- The 2017/18 QOF data showed the percentage of care plans carried out for patients diagnosed with a mental health related condition and patients diagnosed with dementia was below local and national averages. The 2018/19 QOF data showed the percentage had improved for patients diagnosed with dementia; however, remained below local and national averages.
- 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.
- All staff had received dementia training in the last 12 months.
- 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) (QOF)	78.6%	93.2%	89.5%	No statistical variation
Exception rate (number of exceptions).	5.4% (4)	9.5%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	91.7%	93.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	2.7% (2)	7.7%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	70.6%	86.2%	83.0%	No statistical variation
Exception rate (number of exceptions).	5.6% (1)	6.1%	6.6%	N/A

Any additional evidence or comments

To improve the care planning of patients experiencing poor mental health the practice was working with the community mental health team and developed an action plan. For example, the action plan included adding information from any detailed mental health clinic letters to update patient's mental health care plans, ensure appropriate read code were added to reflect this. Staff explained for patients who recurrently failed to attend their mental health clinics, the practice offered the mental health services and patients the option of holding a joint review at the practice to improve engagement.

Staff explained most of the patients on the dementia register for whom they were unable to update their care plans lived in local nursing homes. We were told due to the influx of new patients as a result of the closure of neighbouring practices resources were aimed at responding to changes in demand therefore; members of the clinical team were unable to visit nursing homes in order to carry out routine reviews as well as dementia care plan updates. The practice provided unpublished data from the 2018/19 QOF which showed 77% diagnosed with a mental health related condition had comprehensive, agreed care plan documented in their record and 71% diagnosed with dementia had had their care plan reviewed in a face-to-face consultation. However, members of the management team explained the clinical team had become more stable and the practice developed an action plan to increase the number of care plan reviewed. This included sending a clinician to the local nursing home every six months for one afternoon or a morning to carry out routine reviews and update care plans. Staff explained the practice were planning to repeat the awareness day where they invited Dementia UK to attend the practice in order to hold clinics for patients and their relatives as well as carers.

The practice was incorporating care planning into physical health reviews carried out by the practice nursing team.

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)	543.1	545.6	537.5
Overall QOF score (as a percentage of maximum)	97.2%	97.6%	96.2%
Overall QOF exception reporting (all domains)	4.7%	6.1%	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

<p>The clinical team were able to demonstrate a programme of clinical audits which were completed and ongoing to monitor and improve the effectiveness of clinical care within the practice. For example, the practice with support from prescribing support pharmacists carried out an audit on Urinary Tract Infection (UTI) prophylaxis anti-biotic prescribing. The audit was carried out in September 2017 and repeated in March 2018. Data provided by the practice showed actions taken such as providing clinicians with quick reference guides as well as ensuring clinicians were referring to Public Health England's (PHE) UTI information sheets which was placed in all clinical rooms resulted in improvements. For example, the first audit showed 67% of patients prescribed a long-term antibiotic for the prophylaxis of UTIs had a diagnosis of recurrent UTI recorded in their clinical notes; this had increased to 100% when the audit was repeated. Data also showed UTI prophylactic antibiotic choice for non-pregnant women remained in line with the Pan Birmingham Primary Care Antimicrobial Guidelines across both audits.</p>
<p>The practice carried out monthly audits of high-risk medicine prescribing as well as audits following receipt of patient safety alerts such as those received from Medicines and Healthcare products Regulatory Agency (MHRA). For example, staff explained the Valproate audit was carried out automatically on a yearly cycle. Data provided by the practice showed the audit was last carried out July 2019; actions were in place to ensure appropriate measures were carried out and the practice scheduled a repeat audit to be carried out in six months to monitor progress.</p>

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	

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

Explanation of any answers and additional evidence:

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.	Partial
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence:	

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>	93.9%	96.1%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.5% (6)	0.6%	0.8%	N/A

Any additional evidence or comments

Staff provided examples of care plans and templates used which reflected the use of best practice for patients diagnosed with a long-term condition as well as people living with frailty. However, the practice was aware that care planning for patients with mental health needs and patients diagnosed with dementia was an area which required improvement.

Consent to care and treatment

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

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

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: The management team demonstrated an in-depth awareness of the challenges within the local area and changes such as closures of neighbouring practices over the past couple of years. Staff explained between 2014 and 2018 three neighbouring surgeries had closed and the practice list size had grown over the years from 2,400 to 5,898. The practice identified necessary actions and carried them out effectively to ensure they were able to sustain quality and effectiveness. For example, the practice carried out successful recruitment campaigns to strengthen the practice team which enabled the practice to manage the influx of new patients. The practice leadership development programme included succession plans for key staff in lead roles; as a result, the practice explained they had recruited additional senior staff and existing staff were offering training and mentoring to support them during their induction.	

Vision and strategy

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

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

applied this in their role. The practice aimed to promote a learning environment and culture, to continually improve patient care was well embedded within the practice. The vision also included working effectively with internal and external teams as well as patients to deliver the highest level of care. The practice is a family run practice which was established in 1998; the leadership team demonstrated a deep-rooted passion for delivering inclusive care for the local population and we saw that this translated into the action of the practice.

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
<p>Explanation of any answers and additional evidence:</p> <p>The management team promoted the practice philosophy which was to encourage a learning environment and a culture of continually improving patient care. Staff demonstrated a variety of processes they had embedded to ensure that staff were involved and actively engaged in discussions regarding changes within the practice. For example, the practice held regular clinical and non-clinical meetings; there was opportunity for staff feedback through suggestion boxes and the practice operated an open-door policy. Partners shared thoughts and views about the future of the practice including any identified risks and shared the 2019/20 business plan with staff.</p> <p>There was a lead person responsible for managing and monitoring complaints and significant events. Staff were able to demonstrate systems that were in place to enable the practice to respond to complaints in a timely manner. We saw that incidents were investigated, and learning shared throughout the practice. Patients who were affected by an incident or were unsatisfied with the service provided received an apology.</p>	

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

Source	Feedback
Management team	Members of the management team we spoke with explained that staff at all levels within the team were very supportive, listens to staff ideas and happy to try new ways of working as well as suggestions from the teams to help improve service delivery. Staff explained there was a strong learning culture and clear lines of communication. Staff were encouraged to share any ideas as well as discuss any areas of concern and they felt the management team responded to maintain staff well-being and a positive working environment.
Policies	Practice policies were in place which supported leaders to act on behaviour and

	performance inconsistent with the vision and values of the practice.
Policies and management interviews	The practice had processes which enabled leaders to take action to promote equality and diversity. For example, flexible working options were available, leaders were aware of options available to ensure staff maintained a work life balance and staff received support if they needed time off to care for a child or family member.
Management team	The practice improved their lines of communication which enabled staff to provide feedback, discuss concerns as well as their thoughts around internal issues which impacted on patient satisfaction in a safe environment. The management team explained this enabled the practice to review the practice structure and in the last 12 months actions have resulted in a fresh, energetic and positive team.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
The management team provided examples of structures, processes and systems in place to support the delivery of good quality and sustainable care. For example, systems for managing safeguarding concerns, clinical and environmental risks, recruitment and the effectiveness of care provided were well embedded and oversight of these processes was carried out effectively. The practice operated a process for ensuring policies and procedures were reviewed and updated in line with local and national guidance updates.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Records we viewed showed clear arrangements for managing clinical and environmental risks. For example, the practice carried out fire safety, health and safety, legionella and Control of Substances Hazardous to Health (COSHH) risk assessments. We also saw arrangements in place to enable staff to respond to medical emergencies. The practice had a recruitment policy which ensured all appropriate checks were carried out prior to commencing employment.</p> <p>Members of the management team explained that they assessed the impact on quality and sustainability due to a number of changes within the local area and carried out an action plan which included a restructure of the clinical and non clinical team as well as changes to the governance framework. The management team explained the practice held open and honest discussions with existing staff regarding identified risks and also carried out a recruitment campaign which enabled the practice to sustain service delivery.</p> <p>Data from the 2017/18 QOF data showed mental Health related clinical indicators was below local and national averages. At the time of our inspection, the 2018/19 data had not been published. The practice demonstrated awareness of the issues which impacted on performance in this area and explained actions they were intending to take to improve the management of patients diagnosed with a mental health related condition including patients diagnosed with dementia. Staff demonstrated awareness of the uptake of national screening programmes and the number of TWW referrals which were below local and national averages. There were plans in place to improve performance. For example, more referrals were being carried out and at the time of our inspection the management team were exploring systems to enable the practice to measure the number of referrals made.</p> <p>The practice had a business continuity plan and provided evidence of when they had triggered the plan to enable ongoing delivery of services. For example, the practice received notice to vacate their previous premises and there was a four to five-week period before their new premises was ready. Therefore, during this period, the practice followed their business continuity plan which enabled the practice to continue delivering services with minimum disruption.</p>	

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
Explanation of any answers and additional evidence:	

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
Explanation of any answers and additional evidence:	
<p>In response to patient feedback and results from the 2018 national GP patient survey, the practice introduced telephone triage as the practice identified that several appointments could have been addressed more effectively without the need for a face-to-face consultation. Staff explained this enabled the practice to improve appointment availability. However, following a three-month period the practice discussed progress with PPG members and patients. Staff explained patients felt they would rather have a face to face appointments. As a result, the practice listened to the patients and stopped the telephone triage system.</p> <p>The practice reintroduced extended hours where patients were able to be seen by a clinician from 7am and the practice stopped their Wednesday half day closure which further increased appointment availability.</p> <p>To improve patient's satisfaction with getting through to the practice by phone; the practice introduced a new phone line and at the time of our inspection the practice were in the final stages of arranging a designated room where two call handlers would be allocated to manage the phone lines. The management team explained that this would enable receptionist to respond in a timelier manner to phone calls as well as patients who present at reception.</p> <p>The practice introduced new members who joined the clinical and management team to patients to ensure they were aware of changes in personnel as well as relevant leads and who to contact or speak with if and when they had any concerns or wished to make a complaint.</p>	

Feedback from Patient Participation Group.

Feedback
<p>The practice had an active PPG and explained that they were keen to engage a more diverse and representative members such as younger/ working age people. The practice held meetings with PPG members to discuss proposed changes and explained any suggestions made by members were taken on board.</p> <p>In response to patients' comments relating to staff attitude the management team discussed this as a team and provided a safe environment for staff to express their views regarding the pressures and demands they were experiencing. The management team explained that they explored various ways to better support the team and following ongoing discussions they reconfigured job roles to ensure staff</p>

were placed in roles which complemented their strengths.

We received 23 completed CQC comment cards which were mainly positive about the care and service received. For example, clinical and non-clinical staff were described as professional; patients felt their needs were met, staff were understanding, supportive, caring and always went above and beyond their line of duty. Patients felt they were treated with dignity and respect. Feedback also showed the practice responded swiftly to less positive comments. For example, patients who raised concerns regarding staff not being helpful felt that on their return to the practice their experience was more positive and was satisfied with the support they received.

The practice received 23 positive comments placed on NHS Choices website. Comments showed patients felt staff were professional, caring, were happy with their overall experience and staff were understanding.

Any additional evidence

Staff explained that they recognised the value a local charity shop was adding to the community, as a result the practice was championing to keep the local charity shop open as the practice felt the shop was benefiting the local community as well as their registered patients.

Continuous improvement and innovation

There were 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
Explanation of any answers and additional evidence:	
Oversight of systems for managing significant events showed that these were investigated and responded to in a timely manner with clear evidence of shared learning. The practice had a system in place for managing complaints in a timely manner.	

Examples of continuous learning and improvement

The practice disseminated learned such as informing staff not to send messages relating to referral updates or required actions directly to locums who did not cover clinical sessions on a regular basis as this may result in a delay in picking up the message. To avoid delays staff were advised to send all messages and actions to GP partners and regular locum to avoid actions being missed.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:
<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.