

Care Quality Commission

Inspection Evidence Table

Beechwood Medical Practice (1-538885469)

Inspection date: 12 August 2019

Date of data download: 24 July 2019

Overall rating: Good

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

Effective

Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
<ul style="list-style-type: none">The practice had a nurse practitioner who contacted all patients when they were discharged from hospital to check on their welfare and to arrange further visits or support as needed.They also carried out early morning home visits on the frail and elderly, and were able to prescribe antibiotics with a follow up visit to see if the antibiotics had been started, and whether there had been an improvement to their condition.	

- The nurse practitioner also held minor ailment clinics and saw patients with a range of problems including throat, chest, or ear infections, rashes, urinary tract infections and swollen legs. They were able to link into the rapid assessment teams. The practice provided data which showed that the above actions had resulted in a decrease in A&E attendance from 2017-2018 to 2018-2019.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) (NHSBSA)	1.58	0.70	0.77	Tending towards variation (negative)

Any additional evidence or comments

- The average daily quantity of hypnotics prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) was higher than the local and national averages. We found that the practice had looked at this, considered the safety issues surrounding hypnotics use, and put in place controls to limit the amount prescribed at any one time. We saw unverified data which evidenced a reduction in usage during the first quarter of 2019/2020.

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 medicine 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.
- The practice was actively looking at succession planning and improving the skill set of nurses by encouraging training and learning. Staff had recently taken the diabetic and asthma diplomas with other staff looking to undertake diabetic and COPD training in 2020.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	75.5%	79.7%	78.8%	No statistical variation
Exception rate (number of exceptions).	24.5% (147)	20.6%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	70.8%	78.7%	77.7%	No statistical variation
Exception rate (number of exceptions).	19.0% (114)	14.4%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	84.6%	83.6%	80.1%	No statistical variation
Exception rate (number of exceptions).	23.2% (139)	16.5%	13.5%	N/A

Any additional evidence or comments

- We found that the practice was managing its diabetic patients and practice nurses were able initiate insulin therapy and support very complex patients. The practice held regular diabetic clinics and will only exception report patients after at least three attempts have been made to engage them in long term condition monitoring. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.
- However, we saw that the use of text messages for appointment confirmation had caused coding issues with patients being excepted when they were trying to cancel an appointment. This had

been rectified and unverified data for 2018-2019 showed a decrease in the above exception reporting figures of 24.5%, 19% and 23.2% to 10%, 10% and 16% respectively.

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>	99.0%	74.9%	76.0%	Significant Variation (positive)
Exception rate (number of exceptions).	43.3% (293)	12.2%	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>	94.5%	91.2%	89.7%	No statistical variation
Exception rate (number of exceptions).	19.6% (40)	14.4%	11.5%	N/A

Any additional evidence or comments

- The practice found that this could be a group of patients who they had difficulties engaging with, as they tended not to attend unless they had symptoms. The practice would also not exception report unless the nationally recommended three attempts had been made to invite in for a review of their condition.
- Coding issues had also resulted in a higher than expected exception reporting figure due to the use of a new text messaging system for appointment reminders as, if the patient declined the appointment, this resulted in them being exempted.
- The practice had checked their hospital admission rates as they were concerned that with high exception reporting rates they might have a higher than average A&E or hospital attendance. This proved not to be the case as their figures were in line with those within the locality.
- The practice held clinics on Saturdays and at times more convenient to patients, particularly those of school age, and recently had decided to stop prescribing inhalers unless the patient had been reviewed.
- We examined 12 patient records and found they were receiving appropriate care and treatment.
- We saw unverified data for 2018-2019 which showed a reduction in the above exception reporting figure of 43.3% and 19.6% to 27% and 13.2% respectively.

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	78.2%	82.1%	82.6%	No statistical variation

31/03/2018) (QOF)				
Exception rate (number of exceptions).	6.2% (82)	6.0%	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)	94.7%	89.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	2.6% (4)	6.2%	6.7%	N/A

Families, children and young people

Population group rating: Good

Findings
<ul style="list-style-type: none"> Childhood immunisation uptake rates were just below the World Health Organisation (WHO) targets. 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. The provision of sexual health services had been improved with a nurse being trained in intra-uterine device fitting and the ability to offer sexual health information.

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)	116	125	92.8%	Met 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)	116	129	89.9%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	116	129	89.9%	Below 90% minimum

The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	116	129	89.9%	Below 90% minimum
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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

- Rates were slightly below the 90% target figure for children aged two, as some parents were reluctant for their child to receive the MMR vaccine.
- Unverified data from the same cohort of patients and for the same childhood immunisation areas show rates of over 90% being achieved during 2018-2019.

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 medicines 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)	69.5%	73.6%	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) (PHE)	68.3%	70.6%	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)	52.2%	56.5%	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)	67.9%	71.4%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a	42.2%	53.4%	51.9%	No statistical variation

two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)				
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Any additional evidence or comments

- The practice was aware that their cervical cancer screening rates were below the locality and national average figures and below the national target figure of 80%. They considered that this could be due to the uptake of HPV vaccinations and a subsequent decrease in attendance for cervical screening as younger age females may have thought screening was not necessary until later in life.
- Steps had been taken to address this by, for example, changing the national screening programme letters so that they explained why screening was still needed even though they might have had the HPV vaccine, displayed the practice details and included photos of all staff members who undertake screening. Videos in the waiting room also explained the continued need for screening. To further increase the percentage uptake, the practice was working to produce information in non-English languages as well as providing early morning, late evening and Saturday appointments to make it easier for working age people to attend.
- The practice was aware of a few transgender patients who were living as male but still required cervical screening, as they had not fully transitioned. Reminders had been sent to relevant patients with information of why they should be screened.

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: **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 medicines.
- 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 awareness training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice was a pilot practice Primary Care Mental Health project which involved patients who GPs managed as the patients do not meet the criteria for intervention by the crisis management team. As part of this project, Community Psychiatric Nurses attended the practice on a weekly basis and discussed with patients' ways of them and reintegrating them into the community.
- There was also a social prescriber who went to the surgery monthly to meet with patients on a pre-booked appointment basis. Social prescribing is a way of linking patients in primary care with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and well-being.

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>	95.1%	93.0%	89.5%	No statistical variation
Exception rate (number of exceptions).	35.2% (44)	20.7%	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>	97.8%	91.5%	90.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	28.0% (35)	17.4%	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>	91.1%	82.8%	83.0%	No statistical variation
Exception rate (number of exceptions).	9.7% (6)	6.6%	6.6%	N/A

Any additional evidence or comments

- The exception reporting rate for 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 and whose alcohol consumption also recorded was higher than the local and national averages.

The practice had investigated this and found that although the patients were seen by the secondary care mental health services, they did not always have a care plan in place. The practice was reviewing those patients and putting in place a care plan.

The practice also found that they had a higher than expected number of patients who, as the result of possibly a one-off episode, had been coded as having mental health conditions. These patients did not require a review and were excepted. The practice had recoded these patients and had

reduced the exception reporting figures of 35.2% and 28% to 27.5% and 22.5% respectively.

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)	545.8	544.8	537.5
Overall QOF score (as a percentage of maximum)	97.6%	97.5%	96.2%
Overall QOF exception reporting (all domains)	12.0%	7.3%	5.8%

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

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

- We saw evidence of several audits having been completed. In one, the aim was to reduce the number of patients being prescribed opioids for long term use by 5%. The first search of patients showed a total of 660 patients were prescribed weak opioids. These patients were given information and education leaflets when collecting their prescriptions and, where appropriate, reducing doses. They were also written to with a face to face GP appointment being offered if they wanted.

The second cycle of the audit showed a reduction in patients on opioids from 660 to 557. This reduction in potential opioid dependence also had the benefit of reducing prescribing expenditure on this category of drug and allowed spending to be made elsewhere.
- Another audit of patients who had Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) who were prescribed these medicines on repeat prescriptions was carried out. Guidance recommended that oral NSAIDs should not be taken routinely, unless clinically indicated. Review of patient records and discussion with patients after the first cycle of audit, led to a reduction in numbers of patients taking NSAIDs from 44 to 26.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample	Yes

taking for the cervical screening programme.	
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	n/a
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes

Coordinating care and treatment

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

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

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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their	Yes

own health.	
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
<ul style="list-style-type: none"> The lead receptionist had been trained to offer smoking cessation advice. The nurse practitioner gave health eating advice to patients to encourage them to lose weight if they were clinically obese.. The practice contacted relevant patients to encourage them to participate in bowel screening, to improve take up rates.. Staff had recently attended a training session on explaining to patients how to use the new Faecal Immunochemical Test (FIT) kits. 	

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)	89.1%	94.1%	95.1%	Variation (negative)
Exception rate (number of exceptions).	0.4% (10)	1.1%	0.8%	N/A

Any additional evidence or comments
<ul style="list-style-type: none"> The exception reporting rate was lower than the local or national averages. The practice was aware of this and felt that this led to a lower overall figure of 89.1% when compared to the local and national averages of 94.1% and 95.1% respectively. They were reviewing their exception reporting procedure and also taking steps to ensure that smoking data was captured during long-term condition reviews.

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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes

Source	Feedback
CQC Comment Cards	<p>Patient comments included feedback that the doctors and staff couldn't be faulted; the clinical and non-clinical teams were all extremely good; care needs were met; treatment was good; Staff listened to patients; patients felt cared for; staff went above and beyond with patient care and that the surgery was always clean and well maintained.</p> <p>The mixed comment cards referred to delays in getting test results and a reluctance to see any clinician other than a GP.</p>

Carers	Narrative
Percentage and number of carers identified.	2% (218) of the 11,106 patients were registered as carers.
How the practice supported carers (including young carers).	<p>Carers were identified at point of registration and opportunistically by clinical and non-clinical staff when the patient and/or their carers attend the surgery.</p> <p>Flu vaccinations were offered to carers plus longer appointments if required. There was a Carer's champion who prepared carer's packs and arranged health checks to ensure the carers were receiving appropriate help and support. If necessary carers were signposted to support organisations.</p> <p>The practice had just received a Silver Award from Carers Support Centre (Bristol and South Gloucestershire) for being a dementia friendly practice and for supporting carers.</p>
How the practice supported recently bereaved patients.	<p>Condolences and offers of emotional and practical support would be offered. GPs would contact recently bereaved patients, either by telephone or via a home visit depending on the circumstances.</p> <p>Bereavement packs were provided and support organisations were signposted.</p>

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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
<ul style="list-style-type: none">Regular clinical and staff meetings were held to discuss all clinical aspects of the practice. These included meetings with practice clinical staff practice as well as outside agencies and other health care professionals through multi-disciplinary team meetings. All meetings had an agenda and minutes were recorded.The partners and practice manager met every Thursday morning to discuss staffing needs; finance and premises management to ensure that they were proactive and could respond to changes needed.Staff said that they felt part of a strong team and were supported by the GPs and the practice manager. Staff said they could speak to the practice manager, or a partner, if they had concerns or needed support.Succession planning was in evidence with some partners reducing their sessional commitment as they approached retirement and other clinicians increasing theirs.	

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.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes

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

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

Source	Feedback
Staff	Members of staff we spoke with told us they were very happy working at the practice, morale was high and they felt well supported by the whole staff 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.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes

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.	Yes

There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

Appropriate and accurate information

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

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

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Any unusual access was identified and followed up.	Yes

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.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<ul style="list-style-type: none"> In December 2018 the practice arranged for some of their patients who were carers, to visit the practice and give feedback and identify areas for improvement. The group were pleased with how 	

the practice interacted with patients and offered feedback in terms of access to clinical services and the layout of the premises. A suggestion was made to send out letters in Chinese, informing patients that a support service for Chinese patients was available and that Chinese speaking advocate/carer support practice visits take place every week. This suggestion, and others, was taken up by the practice.

- A new telephone system was installed in 2018 to improve telephone access. More receptionists were made available to take calls at key times and the telephone system integrated with the clinical system to identify callers if they are patients. This ensures that notes are made in the correct patient record.
- Also, as part of the feedback, the appointments system had recently been reviewed to enable more appointments to be pre-bookable rather than on the day appointments.

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.	Yes
Learning was shared effectively and used to make improvements.	Yes

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.