

# Care Quality Commission

## Inspection Evidence Table

### West Road Medical Centre (1-571367307)

Inspection date: 28 August 2019

Date of data download: 09 August 2019

## Overall rating: Outstanding

We rated the practice as outstanding overall in December 2014.

We carried out an inspection of this service due to the length of time since the last inspection. Following our review of the information available to us, including information provided by the practice, we focused our inspection on the following key questions:

- Is the practice effective?
- Is the practice well led?

Because of the assurance received from our review of information we carried forward the ratings for the following key questions:

- Is the practice safe? (Good – December 2014)
- Is the practice Caring? (Good – December 2014)
- Is the practice responsive? (Outstanding – December 2014)

In August 2019, we rated the practice as outstanding overall. This was because:

- There was a clear ethos of working in partnership to meet the needs of patients, particularly those most at risk of otherwise not having good access to healthcare. There was a culture of clinical audit to support the practice to achieve good health outcomes for patients and to continually improve.
- The practice had demonstrated sustained innovation and improvement since the last inspection. The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Leaders were not afraid of safe innovation and strove to continually improve the health outcomes for patients. Change was well managed, and innovation was considered and implemented in a safe way.

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

## Effective

## Rating: Outstanding

We previously rated the practice as outstanding for providing an effective service (December 2014) as the practice was performing highly when compared to similar local practices. The practice was innovative and linked with local charities and organisations to meet the diverse needs of its patients. The practice was proactive in the management, monitoring and improving outcomes for patients. In this inspection (August 2019) we found there was a clear ethos of working in partnership to meet the needs of patients, particularly those most at risk of otherwise not having good access to healthcare.

There was a culture of clinical audit to support the practice to achieve good health outcomes for patients and to continually improve.

### 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
Explanation of any answers and additional evidence: The practice covered an area in the West End of Newcastle which was within the second most deprived area in England. There was high incidence of unemployment in the area (with 22% of people in the area unemployed compared to 5.2% across the clinical commissioning group area, and 4.4% across England, but with a predominantly younger patient group (with many patients in the 15 to 44-year age group). There was also a high proportion who were from black and ethnic minority communities (36.6% from other ethnic groups). Some of these factors were known to impact on the health outcomes of patients and uptake of health services.	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) <small>(NHSBSA)</small>	0.25	0.58	0.77	Variation (positive)

### Older people

### Population group rating: Outstanding

Findings
<ul style="list-style-type: none"> <li>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 was part of a frailty project in the locality. This pilot included those living</li> </ul>

in their own home or in a care or nursing home; housebound or independently mobile patients. It had a focus on advanced care planning, falls prevention, early detection of cognitive impairment, de-prescribing and avoiding unnecessary hospital admission. There were 1500 patients on the frailty register. This equated to 15% of the patient register. The pilot consisted of one GP (although it was planned to increase this to two) and a nurse practitioner working four sessions per week. The practice held multi-disciplinary team meetings, with the district nursing team and the community matron.

The practice had invested in the training of staff to meet the needs of frail patients. This included training from an Admiral Nurse. (Admiral nurses provide specialist dementia support to people with people with all types of dementia, their families and carers). Also, staff were provided with training in the needs of patients with Parkinson Disease. A geriatrician from the local Trust had attended meetings to learn about the model.

As part of the pilot the practice identified those with mild frailty, who would benefit from exercise intervention to reduce the risk of increased frailty. They had used the Year of Care Initiative to identify those patients with long term conditions at risk of becoming frail due to the risk of slips, trip and falls, and included fall prevention activity within care planning. (The Year of Care initiative aims to provide personalised care planning for people with long term conditions by working in partnership with patients and care professionals.)

The practice had referred patients with identified frailty to a range of local social prescribing initiatives, to reduce the risk of loneliness and social isolation, and to support access to advice about things such as housing and benefits.

The practice gave us a case study of a patient who was socially isolated whose wish was to die at home. Through the frailty project, the team put in place an Emergency Health Care Plan to detail the patient's expressed wishes and enact it when capacity to express their wishes had decreased. This enabled support to be put in place at home, to enable them to die peacefully at home.

- The practice provided us with data that through a combination of the local care homes and frailty project, where a preferred place of death was recorded, 100% (in both 2017/18 and 201/19) had died in their preferred place.
- The practice audited the care they provided in a local linked care home (in August 2019) to check they were providing effective care in line with guidelines. This demonstrated that 100% of people living in the care home had a care plan in place, with 60% having an emergency health care plans in place. This met the standards set out in the audit.
- The practice offered same day appointments for patients aged 75 and over.
- 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.

### 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. The practice had long used the Year of Care approach to meet the needs of patients with long term conditions. (The Year of Care initiative aims to provide personalised care planning for people with long term conditions by working in partnership with patients and care professionals.)
- The practice had extended the Year of Care approach beyond those conditions normally covered. They had extended it to include coeliac patients (34 patients); non-alcoholic fatty liver disease (159 patients); and gout and associated conditions (68 patients). The practice had also implemented the Year of Care approach for housebound patients, often as part of the frailty team review. The Year of Care initiative also included input from pharmacists in the clinical team who carried out structured medication reviews with patients.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice was the highest referrer in the local clinical commissioning group (CCG) area to the NHS National Diabetes Prevention Programme. This programme identified those at high risk of developing diabetes and refers them onto a behaviour change programme. The practice had referred 265 patients up to August 2019 and 177 patients had been discharged from the programme. The next highest referred in the CCG area had referred 148 patients (as of May 2019). Data from August 2019 showed that 39 patients from the practice had lost weight successfully.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- 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>	83.2%	79.5%	78.8%	No statistical variation
Exception rate (number of exceptions).	9.6% (60)	14.7%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	80.9%	77.7%	77.7%	No statistical variation
Exception rate (number of exceptions).	9.7% (61)	11.5%	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>	85.5%	82.9%	80.1%	No statistical variation
Exception rate (number of exceptions).	10.9% (68)	12.9%	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>	79.6%	75.4%	76.0%	No statistical variation
Exception rate (number of exceptions).	0.9% (5)	9.2%	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>	91.9%	89.1%	89.7%	No statistical variation
Exception rate (number of exceptions).	4.1% (8)	11.0%	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>	86.9%	84.2%	82.6%	No statistical variation
Exception rate (number of exceptions).	3.1% (34)	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) <small>(QOF)</small>	91.4%	91.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	5.1% (5)	7.9%	6.7%	N/A

#### Any additional evidence or comments

## Families, children and young people

## Population group rating: Outstanding

### Findings

- The practice worked with a local advocacy organisation to prioritise routine enquiry about domestic violence and to take appropriate action where concerns were shared by a patient. Questions about domestic violence had been incorporated in care planning templates to encourage routine discussion with patients. This had led to 177 patient discussions about domestic violence since the beginning of the domestic violence pilot. From these discussions, 22 patients disclosed they were currently experiencing domestic violence. With 13 of these patients having not previously disclosed this information to health professionals. 32 Patients disclosed a history of domestic violence. Where domestic violence was disclosed, patients were reviewed by a domestic abuse advocate specialist and a full risk assessment was carried out. Where appropriate, patients were supported to a safe place to remove them from the domestic violence situation.
- The practice promoted the local 'little orange book' which focused on acute illness in young children and helped parents and carers to recognise and respond to a range of diseases, illness and conditions, as well as signposting parents to the most appropriate service or clinician should they need it.
- The practice had introduced a new protocol in October 2018 to ensure patients who were newly pregnant were seen by a health care professional within a couple of weeks to: provide advice about vitamin D and folic acid supplements; identify any current medical conditions which might be affected or impact the pregnancy and where appropriate arrange for the patient to be seen by a GP; and, to arrange a check on the suitability of current medication by the practice pharmacist.
- Children were offered same day access to appointments.
- Childhood immunisation uptake rates were all in line with the 90% target for England and two were above 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), Hepatitis B (Hep B) (i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	134	142	94.4%	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) (01/04/2018 to 31/03/2019) (NHS England)	145	153	94.8%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	146	153	95.4%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	147	153	96.1%	Met 95% WHO based target

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

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

Population group rating: **Good**

### Findings

- The practice was part of a link project, to support patients who were at risk of needing time off or of losing employment due to mental health or musculoskeletal problems. This project provided patients with access to an advanced health care professional (AHP) and a link worker to identify and support patients with the things they needed to stay in work. The AHP was a registered clinician with advanced clinical practice, in this case an occupational therapist. The link worker identified, signposted and supported patients with their social, emotional or practical needs. The project also aimed to reduce the requirement for GP appointments and for GPs to provide fit notes to patients. The AHPs were able to issue Health and Work Reports as an alternative to a GP fit note. These reports could be used with agreement of the employer, as evidence to support the payment of sick pay. This was in line with guidance issued from HM Revenue and Customs relating to medical evidence from health practitioners to support payment of statutory sick pay. Since the project commenced there had been:
  - 33 referrals to the AHP and nine referrals to the link worker.



- 21 Health and Work reports provided by the AHP, supporting a lower than average issuing of fit notes (1 in 28 working age patients) within the project area, compared to 1 in 46 working age patients nationally over a 12-month period.
- 9 patients returned to work, who were unlikely to have done so without the support of the project.
- The average waiting time from referral to first appointment was 0.67 days.
- Overall, the project caseload consisted of 51% patients with mental health conditions, 33% with musculoskeletal conditions and 14% other conditions. The majority of patients had engaged with the pilot once referred with only 7% of the caseload non-contactable.
- The practice offered e-consultations for patients. Patients could complete an online form, which either signposted them to advice and guidance or sent the online consultation information to the practice for the appropriate clinician to respond to by the end of the next working day.
- 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.
- The practice had identified that due to the multicultural demographic within the practice population (with 36.7% of people with ethnicities other than white in the practice area), travel vaccination was an important consideration for their patients. To help patients seek the right information about travel vaccinations, they had reviewed and refreshed information available on their practice website. They provided travel leaflets in the key languages spoken by their patients as well as the travel risk assessment completed by the patient prior to seeing the practice nurse for assessment and vaccination. The practice had on average 10 patients per week seeking advice on travel vaccinations.

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)	65.0%	N/A	N/A	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	66.3%	73.4%	69.9%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	44.9%	57.9%	54.4%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months,	72.4%	70.4%	70.2%	N/A

who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)				
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)	46.9%	48.7%	51.9%	No statistical variation

### Any additional evidence or comments

- The practice was below the 80% target for uptake of cervical screening in 2017/18. They had identified this as a priority area for improvement and had completed a full 'No Fear campaign' action plan to support increased uptake. The practice had concentrated on increasing the number of patients undergoing this screening by focusing on those patients who had previously been excluded from screening, for example, as they had declined the invites. They had reduced the number of patients who were excluded from the patient cohort to 15 in 2018-19. This compared to 128 in 2017/18. The practice had also introduced the following initiatives to increase uptake:
  - Personal phone calls to patients by the lead nurse or Romanian interpreter to offer advice and reassurance to encourage uptake.
  - Improved wording to invite letter and translation of the letter into seven alternative languages.
  - Training for staff by Cancer Research UK.
  - Regular update emails sent to staff with run rate of cervical screening carried out and numbers required to meet the target.
  - Targeted outreach into community, such as attending Asian ladies' coffee mornings and provision of leaflets.
- The practice did not have access to more up to date summary data for 2018-19, as this was not yet published. But they provided us with the published quarterly data from NHS Digital and Public Health England for the last three quarters in 2018-19. As the indicator had changed, this is shown summarised into two separate age ranges, 25-49 and 50-64.

Age range 50 – 64 – eligible and screened	GP Coverage	CCG Coverage
Qtr 2 18/19	71.2%	75.6%
Qtr 3 18/19	71.3%	75.4%
Qtr 4 18/19	72.2%	75.9%

Age range 25 – 49 – eligible and screened	GP Coverage	CCG Coverage
Qtr 2 18/19	61.8%	67.7%
Qtr 3 18/19	62.6%	67.7%
Qtr 4 18/19	63.4%	68.9%

- The practice told us the quarter on quarter improvement for those women aged 25-49 had happened following the introduction of the 'No Fear' Campaign commenced in Quarter two.

## People whose circumstances make them vulnerable

Population group rating: Good

### Findings

- All patients with a learning disability were offered an annual health check. The practice had set up a dedicated clinic for people with learning disabilities, with a lead nurse to help ensure patients received an annual health check. Where appropriate, the lead nurse carried out home visits to encourage uptake and make the experience of receiving a health check easier for patients. This nurse also followed up where patients had failed to respond to increase uptake and had validated the register to make sure it was accurate. The practice provided us with unverified and unpublished data which demonstrated this had resulted in an increase of annual health checks carried out from 67 of 113 patients (59.3%) on the register in 2017/18 to 93 of 106 patients (87.7%) on the register in 2018/19. The practice had been accredited as a learning disability and autism friendly practice by a national patient advocacy organisation for people with learning disabilities and autism.
- The practice was an Armed Forces Veteran friendly accredited GP practice.
- The practice had identified a gap in service provision to allow them to provide effective care and treatment to patients with dual communication needs (for example, a patient whose first language was not English who also had sensory communication needs). They escalated this to the service commissioner to source an appropriate translator and ensure this provision was considered in future contractual specifications across the clinical commissioning group area.
- Same day appointments and longer appointments were offered when required.
- 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 had in place local social prescribing initiatives to help patients whose circumstances make them vulnerable access other sources of help and support. This included the primary care navigator. (Primary care navigators help to connect vulnerable patients with care and support in the community and provide direct non-medical support.)

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

Population group rating: Good

### Findings

- The practice linked with the Admiral Nursing Service to help support patients diagnosed with dementia and their carers. They also worked together with two other local practices and the local mental health trust to access advice about referrals or prescribing quickly.

- 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.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice had previously delivered an initiative (from October 2016 to March 2018) with a housing charity to offer additional support for patients with mental health diagnosis; chaotic lifestyles; frequent presentations for appointments or who attended the practice in severe distress. Over the initiative patients were offered six one-hour-long appointments within the practice as well as, where required, additional appointments either at the charity premises, or over the phone to support patients with housing or benefit issues. They were linked with an advisor who could assist patients by attending tribunals, filling in benefit forms, organise new housing and liaise with doctors where health problems were identified. This service was no longer in place, but the practice referred patients in need of support with housing and benefits to the primary care navigator. (Primary care navigators help to connect vulnerable patients with care and support in the community and provide direct non-medical support.)

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>	91.8%	91.0%	89.5%	No statistical variation
Exception rate (number of exceptions).	1.2% (1)	12.3%	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>	96.3%	90.5%	90.0%	No statistical variation
Exception rate (number of exceptions).	4.7% (4)	9.7%	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) <small>(QOF)</small>	84.0%	83.4%	83.0%	No statistical variation
Exception rate (number of exceptions).	13.8% (13)	6.6%	6.6%	N/A

## Any additional evidence or comments

### 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)	558.7	541.8	537.5
Overall QOF score (as a percentage of maximum)	100.0%	96.9%	96.2%
Overall QOF exception reporting (all domains)	7.2%	6.4%	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

<p>The practice routinely carried out clinical audit to check on the quality of care provided. For example:</p> <ul style="list-style-type: none"> <li>• They had acted to identify any patients who were potentially hypertensive, by checking all patients who had a blood pressure recording of over 150/90mmHg who were not already diagnosed with hypertension, or part of the Year of Care initiative. They had repeated this exercise over the last three years.</li> <li>• They had carried out an audit to check if consent was being sought appropriately for those patients who had a cervical smear within the last six months. This confirmed consent was obtained appropriately in all cases.</li> <li>• For the local linked care home, they had carried out an audit to check appropriate care planning and end of life care planning was in place.</li> <li>• They had carried out an audit of patients over 60, prescribed oral non-steroidal anti-inflammatory medicines (NSAIDs are medicines that are widely used to relieve pain, reduce inflammation, and bring down a high temperature), to check if any were prescribed proton pump Inhibitors (PPI are medicines used to relieve the symptoms of indigestion and heartburn). This audit was carried out following a significant event. It demonstrated an increase from 36% to 70% of patients who had their risks assessed, and advice and alternative analgesia offered to reduce the risks associated with non-steroidal anti-inflammatory medicines.</li> </ul>
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#### Any additional evidence or comments

The practice had a culture of audit and quality improvement. Frequently, when we asked the practice about processes and procedures they referred us to audits and data collections routinely carried out by staff to evidence they had checked processes achieved their objectives or demonstrated high quality care. For example, there were checks and audits of processes and procedures within the practice, such as timeliness of follow up for workflow actions and tasks, the safety of medicines prescribing, and patient use of online services. The responsibility of this was clearly allocated to staff across the practice.

## Effective staffing

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

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



Explanation of any answers and additional evidence:

There was clear evidence provided through our examination of the different population groups that the practice routinely worked together with other organisations to meet the needs of patients. There was a clear ethos of working in partnership to meet the needs of patients, particularly those most vulnerable and most at risk of otherwise not having good access to healthcare.

## 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 own health.	Yes
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
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) (QOF)	95.8%	95.7%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.6% (12)	0.9%	0.8%	N/A

### Any additional evidence or comments

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## 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
Explanation of any answers and additional evidence:	

## Well-led

## Rating: Outstanding

We previously rated the practice as good for providing a well-led service (December 2014). In this inspection (August 2019) we found the practice had demonstrated sustained innovation and improvement since the last inspection. The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Leaders were not afraid of safe innovation and strove to continually improve the health outcomes for patients. Change was well managed, and innovation was considered and implemented in a safe way.

### 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.	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
Explanation of any answers and additional evidence: Through interviews with GPs and the management team we found leaders demonstrated they had the knowledge, skills and experience to deliver high quality care and treatment. There was a good understanding of the local and national priorities and plans. The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. This was demonstrated by the integral use of performance data and clinical audit to drive improvement; the strong partnership working with other organisations to meet the needs of the local community and make sure the needs of those most at risk of poor health outcomes were met; and the commitment to a whole team approach to delivering high quality care.  Leaders were not afraid of safe innovation and strove to continually improve the health outcomes for patients. We found there were strong governance arrangements which supported innovation safely and continual improvement. This was evidenced through the range and quality of audit and quality improvement work carried out by the practice. The strong leadership within the practice was evident.	

### 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
<p>Explanation of any answers and additional evidence:</p> <p>Through interviews with GPs and the management team we found there was a clear vision and strategy to deliver high quality sustainable care. The practice had a strategy and supporting business plan which reflected the vision and values of the service. This was regularly monitored by the management team. All staff were clearly working towards the same shared goals and aspirations of the practice. Change was well managed, and innovation was considered and implemented in a safe way.</p> <p>The practice had demonstrated sustained innovation and improvement since we last inspected the practice in December 2014, when they were rated as outstanding overall.</p>	

## 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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a very positive patient centred culture, and the staff we spoke with all demonstrated a high level of commitment to providing good quality care. There was a clear commitment to meet the needs of patients and a strong culture of innovation to support sustainability and good quality care.</p> <p>There was a good awareness of the local community and this informed business planning. For example, they had regular translator sessions with a Romanian translator to support good communication with this large community in the area. They had identified those patients most at risk or vulnerable, for example, those patients at risk of domestic violence, patients with learning disabilities and those who were frail, and had worked with partners to develop services to meet their needs and improve health outcomes.</p>	

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

Source	Feedback
Interviews with staff	Staff we spoke to told us they felt they were a good team that worked well together and was supported by management. They said the GPs and management team were approachable and helpful. Staff told us they felt the practice was open in its approach and friendly. Staff told us they received all the training they needed for their roles and had protected time to do so.

## 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
Explanation of any answers and additional evidence: There were clear and transparent policies to govern the way the practice operated and to support staff to provide care and treatment in line with current legislation, standards and guidance.	

## 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
Explanation of any answers and additional evidence:  In December 2014, we said the practice should maintain clear records on prescription stationery stock, in line with guidance from NHS Protect. In August 2019, we found the practice had addressed this area of concern and had made improvements to the safety and security of the prescription stationery.	

## 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
Explanation of any answers and additional evidence: The practice had a culture of audit and quality improvement. They routinely used information they collated about the service to support them to manage risks, issues and to inform service improvements.	

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
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.	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
Explanation of any answers and additional evidence: * The practice operated a virtual group at the time of the inspection. However, a recent email survey of members of the virtual group had identified members who preferred to meet in person. The practice therefore proposed to hold an open evening towards the end of the year as part of the process to start a face to face programme of meetings.  The practice had developed a pictorial feedback form for children and young people to encourage their feedback.	

### Feedback from Patient Participation Group.

Feedback
The practice had a large virtual network and as such we did not contact members of this group for direct feedback. However, the practice shared with us the feedback they had received from patients, as part of the virtual network, comments, complaints and general feedback.
The practice had recently gathered feedback from the virtual group about areas members would like to see improve. This included: <ul style="list-style-type: none"><li>• Improved efficiency with local pharmacy;</li><li>• Appointment waiting times and tackling patients who do not attend for planned appointments;</li><li>• Arrangements for meeting the needs of patients with autism;</li><li>• Improved communication between patients and doctors; and</li><li>• Technology in healthcare.</li></ul>

Any additional evidence

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

Explanation of any answers and additional evidence:

### Examples of continuous learning and improvement

There was a culture of continuous improvement within the practice. For example, the practice had implemented the following initiatives delivered in conjunction with other organisations to meet the needs of patients, particularly those most vulnerable and most at risk of otherwise not having good access to healthcare:

- Frailty initiative
- Domestic violence routine enquiry and onward referral
- Care home initiative
- Year of Care, including for other conditions not normally within this scheme, such as coeliac, non-alcoholic fatty liver disease and gout
- NHS National Diabetes Prevention Programme
- Link project for those at risk of losing employment due to mental health or musculoskeletal problems.

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

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

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

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

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

### Glossary of terms used in the data.

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