

Care Quality Commission

Inspection Evidence Table

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Inspection date: 11 September 2019

Date of data download: 03 September 2019

Overall rating: Requires Improvement

We inspected the practice in May 2015 and rated the practice as good overall. During this inspection we rated the practice as requires improvement as the practice did not have clear and effective processes for managing risks, issues and performance. There was a lack of effective leadership oversight to ensure good governance.

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

Safe

Rating: Requires Improvement

We inspected the practice in May 2015 and rated the practice as good for providing safe services. The practice is now rated requires improvement as not all risks had been assessed and managed. The practice did not have fully embedded assurance systems and had not proactively identified and managed risks. For example, there were no risk assessments in the absence of some emergency medicines and for products containing hazardous substances.

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse. However, policies and procedures required further review.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	No
Policies and procedures were monitored, reviewed and updated.	Partial
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Y

Safeguarding	Y/N/Partial
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Partial
There were discussions between the practice and other health professionals such as health visitors and community matrons to safeguard vulnerable adults and children at risk of harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The manager explained the requirements for patients to register for the online service however, there was no specific policy which took account of patients accessing any online services to provide guidance to staff and ensure consistency.</p> <p>There were policies covering adult and child safeguarding however, there were three versions and a lack of clarity as to which version was in use. The policies were generic, not always updated and personalised to the practice to include for example, the names of the safeguarding leads.</p> <p>A member of nursing staff was not up to date with level three safeguarding children's training, although our discussions with them demonstrated knowledge and awareness they had last completed level three training in November 2015. However, they were on a waiting list to attend the next available course.</p> <p>Staff had received training on chaperoning however, some of the staff we spoke with were not clear on the role of a chaperone.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We looked at three staff files including the file of a recently employed staff member. There was evidence of checks undertaken as part of the recruitment process such as references, application forms and proof of identity. However, the system for recording and monitoring information was not fully effective, the vaccination records for two clinical members of staff were not stored by the practice and were provided to us by the individual staff members.</p>	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person.	Y

Date of last inspection/test: 06.02.2019	
There was a record of equipment calibration. Date of last calibration: 31.05.2018	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Partial
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 26.02.2019	Y
There was a log of fire drills. Date of last drill: 04.09.2019	Y
There was a record of fire alarm checks. Date of last check: 04.09.2019	Y
There was a record of fire training for staff. Date of last training: September 2019	Partial
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 17.05.2019	Y
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>There were data sheets for the control of substance hazardous to health (COSHH), for cleaning products. However, these products had not been risk assessed.</p> <p>The fire risk assessment completed in May 2019, identified 11 actions, although none were assessed as high risk the risk assessment had not been updated to demonstrate progress of the actions. We saw that two staff members had received fire training, however, the practice was unable to confirm if all staff had received training as the system for monitoring staff training was not fully effective as it did not provide an accurate overview.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 01.09.2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 01.09.2019	Y
Explanation of any answers and additional evidence:	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: March 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	Partial
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
An infection prevention and control policy was in place, however, this was not comprehensive for example, there was no details in the policy or reference to areas such as clinical waste or sharps injury.	
We saw some evidence of training for staff however, we were unable to confirm if all staff had received infection prevention and control training as the system for monitoring staff training was not fully effective as it did not provide an accurate overview.	
The overall score from the infection prevention and control audit was 97%, there were 11 actions identified, a number of which related to the need for an overflow system in handwash basins. The practice was in discussions with the landlord regarding refurbishments which would include replacing basins.	
A Legionella risk assessment had been carried out at by an external contractor in February 2019. (Legionella is a term for a bacterium which can contaminate water systems in buildings).	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y

Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence:	

Information to deliver safe care and treatment

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

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

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.96	0.84	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2018 to 30/06/2019) (NHSBSA)	5.5%	7.6%	8.6%	Tending towards variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	4.16	5.14	5.63	Variation (positive)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	1.14	1.78	2.08	Tending towards variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y

Medicines management	Y/N/Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence:	
Data showed the prescribing of some antibiotics was lower therefore better than the local and national average.	
There were gaps in the medicines required in the event of a medical emergency. The practice had no risk assessments in place that provided a clear rationale for the decision to not stock these medicines and how a situation would be managed if it was required.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong, however the system to report incidents was not fully embedded.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	50 (approx.)

Number of events that required action:	unclear
Explanation of any answers and additional evidence:	
<p>The practice used an electronic system to report significant events. There was evidence that a large number of significant events were identified, acted on and learning shared with staff. However, the system for recording these was not fully effective as not all events were recorded. There were examples of significant events that had occurred and discussed in meetings that had not been recorded on the system. This did not ensure effective oversight of all events so that themes and trends could be easily identified in order to improve the service.</p>	

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

Event	Specific action taken
Patient prescribed a medicine that was contraindicated	Discussed learning in staff meeting, reinforced to staff the importance of reviewing all medications to ensure appropriate contraindications are identified and actioned.
Secondary care service informed the practice that blood samples sent to them for testing have not been received or samples were not adequate for testing	Discussions with the wider primary care network and GP link for the secondary care service to seek clarification on the issue and address it.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	
We saw examples of actions taken on recent alerts for example, regarding sodium valproate.	

Effective

Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
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
Explanation of any answers and additional evidence:	

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) (01/07/2018 to 30/06/2019) (NHSBSA)	0.73	0.75	0.75	No statistical variation

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. The practice carried out structured annual medication reviews for older patients.

- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age. At the time of the inspection 84% of patients had been reviewed.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice had dedicated clinics for COPD where patients had spirometry undertaken and offered rescue packs.
- The practice had a GP lead for diabetes and a nurse who had received additional training in diabetes. Regular clinics were held to assess and review patients, initiate injectables and ensure ongoing monitoring. QOF indicators for diabetes showed the practice was similar or above local and national averages with lower levels of exception reporting.
- 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 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>	80.5%	80.1%	78.8%	No statistical variation
Exception rate (number of exceptions).	4.7% (13)	12.5%	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>	90.0%	77.2%	77.7%	Variation (positive)
Exception rate (number of exceptions).	2.9% (8)	10.4%	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) <small>(QOF)</small>	89.1%	81.3%	80.1%	Tending towards variation (positive)
Exception rate (number of exceptions).	5.0% (14)	11.4%	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>	77.1%	76.6%	76.0%	No statistical variation
Exception rate (number of exceptions).	0.3% (1)	6.3%	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>	93.7%	91.4%	89.7%	No statistical variation
Exception rate (number of exceptions).	2.7% (4)	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	86.1%	83.1%	82.6%	No statistical variation

measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>				
Exception rate (number of exceptions).	0.4% (3)	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>	87.8%	88.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	12.9% (11)	8.2%	6.7%	N/A

Any additional evidence or comments

Outcomes for patients with long term conditions were mostly comparable to the local and national average but with lower levels of exception reporting.

Families, children and young people

Population group rating: Good

Findings

- Childhood immunisation uptake rates were mostly in line with 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.

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) <small>(NHS England)</small>	46	53	86.8%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)	44	45	97.8%	Met 95% WHO based target

(01/04/2018 to 31/03/2019) (NHS England)				
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)	44	45	97.8%	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)	44	45	97.8%	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

The practice was slightly below the target range of 90% for the percentage of children aged 1 who had received primary course of immunisation. We saw that the practice actively encouraged uptake and followed up children who did not attend and there had been some children who had not received their immunisation as the parents/carers had declined. The practice provided unvalidated data from the Child Health System which showed for the most recent quarter the practice achievement for this immunisation was 90%.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- The practice's uptake for cancer screening was slightly below the 80% coverage target for the national screening programme.
- Cancer detection rates resulted from a two-week wait was lower than the local and national average.

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)	76.9%	N/A	N/A	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	73.5%	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)	54.5%	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)	92.9%	74.2%	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)	43.8%	52.1%	51.9%	No statistical variation

Any additional evidence or comments

The practices uptake for cervical screening was, below the national screening programme target. The detection rate for cancer was lower than the local and national average. The practice was trying to improve uptake by encouraging patients to undertake screening, appointments were offered in the evenings and weekend through the extended access service. The practice actively followed up patients who did not attend screening. A member of staff followed up patients by telephone calls and personalised letters were sent promoting uptake. Messages were added to patient's prescriptions and alerts on patient's electronic records as reminders. We saw recent QOF data although not comparable data, showed the practices current uptake for cervical screening at 82%.

A member of administrative staff coordinated urgent two week wait referrals and we saw there was an effective system in place to ensure referrals were sent in a timely manner and arrangements in place to follow up any delays.

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 medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	93.8%	93.3%	89.5%	No statistical variation
Exception rate (number of exceptions).	1.5% (1)	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) <small>(QOF)</small>	95.4%	93.4%	90.0%	No statistical variation
Exception rate (number of exceptions).	1.5% (1)	7.8%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed	92.3%	85.9%	83.0%	No statistical variation

in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	4.9% (2)	6.0%	6.6%	N/A

Any additional evidence or comments

Outcomes for patients experiencing poor mental health were mostly above the local and national average with lower levels of exception reporting.

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)	558.5	546.1	537.5
Overall QOF score (as a percentage of maximum)	99.9%	97.7%	96.2%
Overall QOF exception reporting (all domains)	3.0%	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

The practice had completed both clinical and non-clinical quality improvement activity. Clinical audits focused on prescribing in areas such as hypnotics and pain relief medicines, full cycle audits demonstrated reduced prescribing in these areas. Non-clinical quality improvement activity included audits of infection prevention and control, health and safety and patient feedback surveys.

Effective staffing

The practice did not have effective systems to manage staff training.

	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.	Partial
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.	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.	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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The system for monitoring staff training was not fully effective as it did not provide an accurate overview to assess and manage learning and development. For example, we were unable to confirm if all staff had completed fire and infection prevention and control training although staff spoken with were aware of the policies and procedures. Staff had received training on chaperoning however, some of the staff we spoke with were not clear on the role of a chaperone.</p> <p>The practice had an arrangement with an external company to support with any human resources issues. However, there were no practice specific policies or procedures in place in areas such as performance management.</p>	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y

Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A
<p>Explanation of any answers and additional evidence:</p> <p>The practice worked closely with various services and organisations to support patients and ensure care was delivered in a coordinated way. For example, community mental health services, the palliative care teams and the community midwife and health visitor.</p> <p>The practice did not provide any digital services, patients were able to book appointments and order prescriptions online once they had registered for the service.</p>	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <p>A number of services were provided in-house such as smoking cessation, sexual health, counselling and spirometry.</p>	

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>	98.0%	96.1%	95.1%	Tending towards variation (positive)
Exception rate (number of exceptions).	0.2% (2)	0.6%	0.8%	N/A

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: Discussion with clinical staff showed that verbal consent was always obtained before care and treatment and where relevant written consent for example, for certain treatments. Clinical staff spoken with were aware of the importance of consent and showed understanding of areas such as best interest and Gillick competency.	

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. Overall people reported they could access the service in a timely manner.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The feedback from patients overall was positive, patients reported they could access the service when needed. However, some patients reported that they were not always able to access the service which impacted on flexibility and choice.</p> <p>The doors to the entrance of the building were not automatic, patients in a wheelchair would require assistance to enter the premises. There was a bell for patients to ring for assistance however, there was no associated signage in place to alert patients to that support was available.</p> <p>Information leaflets in other languages and in easy read format were not readily available in the practice but could be ordered on request.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.30am to 12.30pm then 1.30pm to 6.15pm
Tuesday	8.30am to 12.30pm then 1.30pm to 6.15pm
Wednesday	8.30am to 12.30pm then 1.30pm to 6.15pm
Thursday	8.30am to 1pm Closed pm *when the practice is closed during core hours cover is provided by a GP service contracted by the practice
Friday	8.30am to 12.30pm then 1.30pm to 6.15pm
Appointments available:	
Monday	8.30am to 11am then 2pm to 5.30pm
Tuesday	8.30am to 11am then 2pm to 5.30pm

Wednesday	8.30am to 11am then 2pm to 5.30pm
Thursday	8.30am to 11am Closed pm *when the practice is closed during core hours cover is provided by a GP service contracted by the practice
Friday	8.30am to 11am then 2pm to 5.30pm
	*Appointment start times may vary in the afternoon depending on the GP
Extended access service opening times:	
	<p>Monday to Friday 6.30pm to 8pm Saturday 9am to 1pm Sunday 9am to 1pm</p> <p>The extended access service was provided as part of a joint working arrangement with other local practices within the Primary Care network.</p> <p>Extended access appointments were booked by patients through their GP practice and patients are seen at Oakwood Surgery, Sparkhill, Monday to Friday, and on a Saturday and Sunday. Patients are also seen at Druids Heath Surgery on a Saturday.</p>

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4683	323	102	31.6%	2.18%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	98.9%	93.2%	94.5%	Tending towards variation (positive)

Any additional evidence or comments

The practice was above the local and national average for patients reporting their needs being met at their last appointment. This was aligned with the positive feedback we received from patients on the day of the inspection from speaking with patients and completed comment cards.

Older people

Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- Services benefiting older people were available in-house such as phlebotomy, diabetes and rheumatology clinics.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.
- A number of services were available at the practice reducing the need to attend secondary care such as phlebotomy, anticoagulation clinics, diabetes, acupuncture, spirometry and smoking cessation.

Families, children and young people

Population group rating: Good

Findings

- Appointments were available outside school hours.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The premises had baby changing facilities.

Working age people (including those recently retired and students)

Population group rating: **Good**

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- A range of appointments were offered including pre-bookable, and telephone consultations.
- Patients could book appointments and request repeat prescriptions online. The practice actively promoted online registration. A total of 25% of the practice population had registered for the online service and 51% were registered for the electronic prescription service.
- The practice was a member of a GP hub which meant pre-bookable appointments were available to all patients at a location within the area Monday to Friday from 6.30pm to 8pm. Appointments were also available on the weekend from 9am until 1pm.

People whose circumstances make them vulnerable

Population group rating: **Good**

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. Longer appointments were offered, and home visits were available for health checks and blood tests.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- Patients were referred to counselling services and there were arrangements in place to share information and discuss concerns with the mental health team.

Timely access to the service

People were not always able to access care and treatment in a timely way. The practice was taking action to address this.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when necessary.	Y
Explanation of any answers and additional evidence: Patients requesting a home visit were triaged by the duty doctor who called the patient to assess their needs.	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019)	58.8%	58%	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	71.2%	61.4%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice	57.7%	61.2%	64.7%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
appointment times (01/01/2019 to 31/03/2019)				
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	85.9%	69.0%	73.6%	No statistical variation

Any additional evidence or comments

The practice was below the national average for getting through to the practice by phone and satisfaction with appointment times.

During this inspection there was evidence that the practice was taking action to understand and address the issue of access and improve patient satisfaction. There was active patient engagement through the patient participation group (PPG) and in-house patient survey. Results of the practices in-house survey undertaken in January 2019, showed the following results from the 130 surveys completed. When asked how easy it was to get through to someone at the GP practice on the phone, 17% reported very easy, 48% reported fairly easy, 19% reported not very easy and 12% reported not at all easy. When asked if they needed to see a GP urgently they were normally seen on the same day 70% reported yes and 12% reported no. 17% of patients reported it was easy to book ahead and 44% reported it was fairly easy, 13% reported not very easy and 9% not easy at all.

Actions the practice had taken to improve access included:

- The practice was in the process of installing a new telephone system which would provide a call queue and call option system.
- Since our previous inspection the practice had employed a phlebotomist (one day a week) one additional administrative staff and an administrative manager (one day a week) to improve workflow.
- Regular locum GPs were employed, and the practice had increased capacity for trainee GPs from two to three.
- The practice offered extended access service from 6.30pm to 8pm Monday to Friday, 9am to 1pm Saturday and Sunday. This was offered at a local practice as part of extended access service within a GP hub.
- The practice was encouraging patients to register for online services and to date 25% of patients had registered. The practice had increased the number of appointments available to book online for the nurse.
- Patients were able to book same day appointments which were now released morning and afternoon each day to ensure appointments were available throughout the day. Patients requesting urgent appointments were seen on the same day. Pre-bookable appointments were available up to two weeks in advance for a GP and three weeks for a nurse.
- There was a number of patients that did not attend (DNA) their appointment. The practice was raising patient's awareness to cancel where necessary and patients were now sent text reminders for appointments and letters when they DNA. At the time of the inspection a full analysis had not been completed to assess impact.
- Where a patient had booked an appointment with a GP or the nurse practitioner for 20 minutes or more, the patient received a telephone reminder call from a member of the administrative team.

Source	Feedback
CQC comment cards	There was mixed feedback in eight of the 43 comment cards we received. Patients reported access to appointments as the one area for improvement.
Patient interviews	We spoke with six patients including two members of the Patient Participation Group (PPG). Two patients commented that it was sometimes difficult to get through to the practice by phone and access appointments when needed.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	Four
Number of complaints we examined.	One
Number of complaints we examined that were satisfactorily handled in a timely way.	Partial
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Zero

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Complaints were discussed in team meetings and we saw evidence of one complaint which was responded to appropriately. Verbal complaints were recorded in a complaints book and all complaints were discussed in an annual complaints review. However, the recording of complaints was not comprehensive and lacked oversight, there was no overall system that provided an overview of when complaints were received, acknowledged and responded to. We were not able to view the associated correspondence for all of the complaints to establish if they had been responded to in a timely manner.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient booked for a procedure that was no longer offered at the practice.	Staff reminded to check all patients already booked in advance of appointment and advise accordingly, patient contacted and provided with apology.
Patient provided with incorrect test results	Reinforced to staff the need to take extra when providing test results. Learning shared with staff at team meeting.

Well-led

Rating: Requires Improvement

We inspected the practice in May 2015 and rated the practice as good for providing well led services. The practice is now rated requires improvement, there was a lack of effective leadership oversight to ensure good governance. Systems and processes were not always embedded to ensure risks were identified and managed.

Leadership capacity and capability

There was compassionate, inclusive leadership at all levels. However, there was a lack of leadership oversight to consistently 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.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Partial
Explanation of any answers and additional evidence:	
The practice leaders at Drs Yap, Hughes and Michael were aware of the challenges they faced and were taking action to address these such as increasing access to appointments, recruitment of clinical and non-clinical staff, plans to change the telephone system and implement a workflow system to reduce burden on clinicians. However, leadership capacity and sustainability had not been fully assessed, we saw areas where managerial oversight was not carried out effectively. For example, there were gaps in policies and procedures and systems and processes for monitoring significant events complaints and staff training were not fully effective.	
There was no formal leadership programme however, leaders shared with us plans for sustainability. This included reviewing the premises to ensure the facilities were up to date for the services delivered and increasing the number of trainee GPs to maintain continuous learning and development and support future recruitment.	

Vision and strategy

The practice had a clear vision but it was not supported by a 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.	Partial
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.	Partial

Explanation of any answers and additional evidence:

Leaders at Drs Yap, Hughes and Michael had identified areas for the development and sustainability of the practice and improving the service for patients. We saw evidence of progress in relation to these areas which included increasing staffing levels and working within a wider primary care network to increase access and implement services such as social prescribing. However, progress against delivery of the strategy was not monitored effectively, we identified gaps and inconsistencies in systems and processes which did not support the vision and strategy.

Culture

A culture of open and honesty was encouraged with the aim to deliver high-quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial
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.	Partial
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.	N
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was no practice specific policies or procedures in place in areas such as performance management.</p> <p>Leaders were aware of the requirements of the duty of candour and staff spoken with understood the importance of being open and transparent. However, there was no specific policy in place to ensure a consistent approach.</p> <p>There was a whistle blowing policy which allowed staff to refer any concerns. However, there was no delegated speak up guardian. Staff spoken with were confident to raise any concerns and felt they would be listened to.</p>	

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

Source	Feedback
Staff	Staff commented that leaders in the practice were supportive and approachable and they felt confident to raise any issues.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management. However, some lacked effective oversight.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
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:	
<p>Policies were available in paper format and on an electronic system which were easily accessible to all staff. Discussion with staff showed understanding and awareness of key policies such as safeguarding and whistleblowing. We looked at a sample of policies however, we saw gaps and inconsistencies, not all policies were dated or personalised, some lacked detail for example, the infection prevention and control and safeguarding policy, there were no policies in place for performance management or duty of candour.</p> <p>The system for monitoring staff training and development was not comprehensive. Not all staff had received safeguarding training appropriate for their role, some staff lacked awareness on the role of the chaperone. We were unable to establish if all staff had received training in fire and infection prevention and control.</p>	

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Partial
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<p>The practice did not have fully embedded assurance systems and had not proactively identified and managed risks. For example, there were no risk assessments in the absence of some emergency medicines and products containing hazardous substances. The fire risk assessment was not updated to demonstrate actions completed, some staff lacked awareness on the role of the chaperone. The system to record staff vaccinations was not effective. These risks had not been effectively managed by</p>	

the practice's own quality assurance system.

The major incident plan was not dated although the manager confirmed it had been recently reviewed. Staff had not received formal training in preparation for a major incident but were aware of responding to an emergency, the major incident plan was accessible to staff.

Appropriate and accurate information

The practice used data and information to drive and support decision making although there were gaps and inconsistencies.

	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.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
<p>The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. The practice was mostly comparable to local and national averages for QOF indicators. The practice's uptake for cervical screening was similar to the local and national averages however, below the 80% coverage target for the national screening programme. The practice was aware and taking action to address this. Staff meetings, appraisals and annual complaints review provided the opportunity to monitor performance. However, not all information was accurate, reliable or timely. Electronic records were not always updated to show actions taken as a result of test results, the monitoring of staff training lacked oversight.</p> <p>The arrangements for identifying, managing and mitigating risks were not always effective in areas such as emergency medicines and the control of substance hazardous to health (COSHH).</p>	

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Any unusual access was identified and followed up.	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>The practice had gathered feedback from patients through the patient participation group (PPG), surveys and comments and complaints received to improve patients experience of the service. An in-house survey had been completed in January 2019, 130 surveys were completed. Actions taken as a result of feedback included, increasing access to appointments and plans to install a new telephone system.</p> <p>The results of the most recent national GP survey showed that the practice was above the local and national average in some questions. The practice was above the local and national average for patients reporting their needs being met at their last appointment. This was aligned with the positive feedback we received from patients on the day of the inspection from speaking with patients and completed comment cards.</p> <p>The practice was below the national average for getting through to the practice by phone and satisfaction with appointment times. The practice acknowledged ongoing work was required to sustain positive feedback and ensure ongoing monitoring of the quality of the service.</p>	

Feedback from Patient Participation Group.

Feedback
The practice had a patient participation group (PPG). We spoke with two members who told us there were approximately 10 members and they met once every three months to discuss ideas and service improvement. They told us that patients views, and concerns were encouraged. There was a good relationship with the practice, the lead GP and practice manager attended all meetings, this ensured collaborative working.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
The practice was a training practice for GPs and had recently increased the number of trainees.	

Examples of continuous learning and improvement

Learning and improvement was encouraged through staff appraisals and meetings. The practice made use of internal and external reviews of incidents and patient safety alerts and learning was shared and used to make improvements. A number of clinical audits were completed and provided the opportunity to learn and improve.

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.