

# Care Quality Commission

## Inspection Evidence Table

### Dr Shepherd & Partners (also known as Filey Surgery) (1-540367877)

Inspection date: 11 September 2019

Date of data download: 27 August 2019

## Overall rating: add overall rating here

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

## Safe

Rating: Good

### Safety systems and processes

The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

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.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
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.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency	Y

staff and locums).	
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

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: September 2018	Y
There was a record of equipment calibration. Date of last calibration: 14 September 2018	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 20 September 2018	Y
There was a log of fire drills. Date of last drill: 27 June 2019	Y
There was a record of fire alarm checks. Date of last check: Weekly checks were carried out.	Y
There was a record of fire training for staff. Date of last training: Staff completed on line training and completion was checked by the manager.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 7 March 2019	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 5 February 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 14 August 2019	Y

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: 11 September 2019	
The practice had acted on any issues identified in infection prevention and control audits.	P
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.	
<p>Explanation of any answers and additional evidence:</p> <p>The practice had not completed an annual infection prevention and control audit until the day of the inspection.</p> <p>We saw that the practice completed deep cleaning of the practice every six months and handwashing audits every four weeks. The practice had introduced room cleaning schedules.</p> <p>We saw that in one examination room being used there was no handwashing facilities and there was no risk assessment in place to determine what measures were in place to ensure effective control and prevention of infections.</p> <p>In addition, we saw that there was no risk assessment in place for staff taking blood samples to the hospital in their own vehicles.</p>	

## 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	Y

unwell patient and had been given guidance on identifying such patients.	
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

### Information to deliver safe care and treatment

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

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

## Appropriate and safe use of medicines

### The practice did not have some systems in place 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)	0.98	0.94	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)	4.5%	4.6%	8.6%	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)	5.50	5.74	5.63	No statistical variation
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)	2.53	2.60	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	P
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).	P
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	Y

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
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.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
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.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The medicine stocks were maintained against an agreed list by one of the advanced practitioners and were replaced when an agreed level was reached. Access was by a magnetic release key which was not readily visible. However, the security of this key had not been risked assessed to ensure only authorised staff could access the medicines in the cupboard.</li> <li>• We looked at a sample of Patient Group Directives (PGDs) all were up to date and signed by the nurse to say they were competent to administer.</li> <li>• The emergency medicines were stored within one of the treatment rooms in two grab boxes (adult and paediatric anaphylaxis kits) in a crash trolley and the main medicines cabinet which was locked with a magnetic release key. However, this storage had not been risked assessed to ensure secure but easy access if needed in an emergency.</li> <li>• A regular stock check was undertaken of controlled medicines by the dispensary staff however when a stock check was carried out on the day of the inspection a discrepancy was noted between the stock held and the amount recorded in the register for two items. It was confirmed that this had been a recording omission and it was reported to the Accountable Officer for Controlled drugs for further investigation. It was also noted that a similar error had occurred previously. The practice provided assurance that action had been taken to prevent reoccurrence.</li> <li>• The practice employed a Pharmacist who provided advice about prescribing, carried out clinical audits and ensured appropriate changes were made following the receipt of alerts and guideline updates. The Pharmacist provided advice to the prescribers to ensure best practice against national guidelines.</li> </ul>	

<b>Medicines management</b>	<b>Y/N/Partial</b>

<b>Dispensary services (where the practice provided a dispensary service)</b>	<b>Y/N/Partial</b>
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	P
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Y
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Y
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>Explanation of any answers and other comments on dispensary services:</p> <ul style="list-style-type: none"> <li>• The Vaccines were kept in lockable fridges which were clean and well maintained. However, the key to one of the fridges was an unlocked cupboard within the treatment room. This was addressed by the practice on the day of the inspection.</li> <li>• One of the Vaccine fridges was slightly overcrowded which had led to a couple of vaccines being pushed on to the back panel causing them to be frozen. This was rectified immediately.</li> <li>• The practice had recently purchased an extra fridge to deal with the storage of Flu vaccines.</li> </ul>	

## Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	13
Number of events that required action:	13

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

Event	Specific action taken
A referral was made by the practice using the 'two week' wait and the process was rejected.	The practice reviewed the referral process for requests where an ultrasound scan was required prior to a referral. The practice had raised this with the Clinical Commissioning Group as a possible delay to the process and now ensured all ultrasound scans in these circumstances were requested as urgent.
A paediatric patient was given a medicine where there may have been contraindications to prescribing.	The practice improved the process for ensuring such alerts relating to individual patients flashed up when prescribing was attempted.

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: When the practice received alerts, they were recorded on a spread sheet and then disseminated to the appropriate practitioner for action. When the action had been taken it was then added to the spread sheet. We saw a couple of gaps in the actions section of the spreadsheet. However, it was then confirmed that the actions had been taken.	



## 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.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had introduced the use of Arden's, a clinical decision and support tool. It provided clinicians with easy access to evidence-based resources, promoted best practice, prescribing and patient safety.</p> <p>The practice received a weekly Newsletter from the CCG which provided information updates such as current evidence-based practice.</p> <p>Using digital services patients were currently able to book appointments, order prescriptions and request access to their records online.</p>	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) <small>(NHSBSA)</small>	0.62	0.67	0.75	No statistical variation

## Older people

## Population group rating: Good

- 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 currently has 600 frail patients identified with a care plan in place.
- 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. All staff had completed dementia training.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## People with long-term conditions

## Population group rating: Good

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.
- The practice identified any patient who were hard of hearing or deaf and placed an alert on their records. The practice used, Skype Sign, and one member of staff had been trained in British Sign Language (BSL).

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>	86.6%	83.0%	78.8%	No statistical variation
Exception rate (number of exceptions).	13.8% (100)	16.5%	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>	84.4%	79.2%	77.7%	No statistical variation
Exception rate (number of exceptions).	5.0% (36)	12.2%	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>	83.0%	82.0%	80.1%	No statistical variation
Exception rate (number of exceptions).	25.4% (185)	20.5%	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>	71.7%	80.7%	76.0%	No statistical variation
Exception rate (number of exceptions).	3.3% (23)	10.9%	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>	95.1%	93.8%	89.7%	No statistical variation
Exception rate (number of exceptions).	15.0% (25)	12.7%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	87.8%	84.8%	82.6%	Tending towards variation (positive)
Exception rate (number of exceptions).	2.6% (47)	5.6%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	95.0%	91.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	7.3% (22)	7.2%	6.7%	N/A

#### Any additional evidence or comments

The practice was aware of high exception rates and were changing the recall systems for Long Term Conditions to improve attendance.

#### Families, children and young people

#### Population group rating: Good

#### Findings

- Childhood immunisation uptake rates were above the World Health Organisation (WHO) target for children aged one and below the minimum 90% rate for the three immunisations given to children aged two.
- 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. The nurses in the practice had undertaken training in sexual health.
- 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)	72	74	97.3%	Met 95% WHO based target
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)	79	90	87.8%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	79	90	87.8%	Below 90% minimum
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)	79	90	87.8%	Below 90% minimum

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 working with the health visitors and contacting families to improve uptake of childhood immunisations.

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

Population group rating: Good

### Findings

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

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	73.6%	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)	74.6%	70.9%	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)	61.3%	59.0%	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)	58.0%	66.3%	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)	49.5%	49.7%	51.9%	No statistical variation

#### Any additional evidence or comments

The practice was aware that the uptake of cervical cancer screening was below the national average and were encouraging patients to attend and using follow up invitation letters. Another nurse had completed her cytology training improving access to appointments.

#### People whose circumstances make them vulnerable

#### Population group rating: Good

- 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 considered 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.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.



Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	91.7%	92.3%	89.5%	No statistical variation
Exception rate (number of exceptions).	23.4% (11)	18.3%	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) (QOF)	95.1%	95.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	12.8% (6)	14.9%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	74.2%	81.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	17.5% (14)	9.6%	6.6%	N/A

#### Any additional evidence or comments

The practice was aware of high exception rates and was changing the recall systems for Long Term Conditions to improve attendance.

#### 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)	556.4	554.8	537.5
Overall QOF score (as a percentage of maximum)	99.5%	99.3%	96.2%
Overall QOF exception reporting (all domains)	6.2%	7.1%	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	Y

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

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| <ul style="list-style-type: none"> <li>• An audit was undertaken following National Institute for Health and Care Excellence (NICE) guidance to identify patients prescribed metformin (a medicine used in the treatment of type two diabetes) and the risks of prescribing this medicine for patients with renal impairment. Following the audit patients were reviewed more regularly and their dose stopped or reduced. The practice was also considering including a tick box as part of the diabetic review as a prompt to consider if the metformin dose needed reviewing or stopping following the checking of the renal function</li> <li>• An audit was undertaken to ensure the Oestrogen only Hormone Replacement Therapy (HRT) was not prescribed to patients who had not had a hysterectomy. The patients were identified and reviewed showing that prescribing had followed national guidelines. The practice continued ongoing monitoring of this patient group.</li> </ul> |
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### Effective staffing

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

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

were able to attend training held by the CCG.

### 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 were discussed (01/04/2017 to 31/03/2018) <small>(QoF)</small>	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.	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

## 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>The practice was working with the CCG on referral pathways, for example, Rapid Expert Input, Advice and Guidance Audit.</p> <p>The practice was working with the newly established primary care network (PCN).</p> <p>The practice also used Teamnet which they were sharing across the PCN. Teamnet was a web-based platform for sharing, exchanging and collaborating across GP practices and Primary Care groups.</p> <p>The primary care networks are a group of local practices who work together to improve services for their local population.</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>	96.1%	95.7%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.5% (15)	0.9%	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



## Well-led

Rating: Good

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: During the previous year the practice had experienced high levels of long-term staff sickness effecting clinical staff. To support the staff, the practice suspended long term conditions checks for one month to alleviate the pressure on the clinical staff still at work. Following this month, the appointments were recommenced and any impact on patients monitored.	

### Vision and strategy

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

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

## Culture

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

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

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

Source	Feedback
Staff interviews	The staff we spoke with without exception were complimentary about the practice and told us they were supported by the clinicians and management team. They told us that the practice manager and team leaders continually offered support and encouragement. Staff told us they were part of a happy team working in the practice with a shared vision.

## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• The practice held meetings on a regular basis</li> <li>• Staff were organised into teams with staff holding key roles and responsibilities.</li> <li>• There was good access to training at all levels.</li> <li>• The practice promoted a no blame culture.</li> </ul>	



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**Managing risks, issues and performance**

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
The practice had a practice had a positive approach to audit having undertaken 20 audits over the last year.	
Staff were aware of the major incident plan and what to do in an emergency but had yet to receive formal training.	

**Appropriate and accurate information**

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
We saw the practice had a proactive approach to service improvement. They undertook regular meetings to discuss significant events, audits and complaints.	

The practice also undertook surveys, for example 'Patient Satisfaction with access to Minor Illness Practitioners'. The Feedback was positive, 85% of patients found the consultations very good and 14% found them good.

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

## 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The Patient Participation Group (PPG) meet four times a year with the practice staff and were consulted on a range of issues. The group had their own notice board inclusive of photographs of the group and contact details to encourage patients to raise issues or concerns. There was also a PPG suggestion box in reception where patients could post their suggestions.</li> <li>• The practice and PPG produced a patient newsletter four times a year to keep patients informed of changes and health initiatives locally. The group worked with other local groups such as 'Filey Community Voice' and the CCG wide PPG group.</li> <li>• The PPG organised local Health and Wellbeing events within the local community to promote local health issues and what help was available.</li> <li>• The group were also involved in Flu campaigns and promoting the summarised care record.</li> </ul>	

Feedback from Patient Participation Group.

Feedback
<p>We spoke with a member of the PPG who outlined how the group worked proactively with the practice, patients and local community to promote good health care locally. The group of nine members were supported by the practice manager, secretary and a GP. The group as well as organising local health and well-being events had delivered talks to local community groups promoting the practice and health agenda.</p>

## 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
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### Examples of continuous learning and improvement

The practice has a proactive approach to strive for continuous improvement. The practice was supportive and promoted staff development. Examples of these were; the paramedic had gained an advanced care practitioner qualification; the extended role nurse has gained a nurse prescriber qualification and other staff had gained further qualifications and national vocational qualifications. We also saw that GPs were undertaking further training and qualifications. The practice also provided advanced training of doctors who wish to become General Practitioners, training for medical students, student nurses and those wanting work experience.

The practice regularly reviewed their workforce, developing new roles to meet the needs of their patient group. Examples of these were employing a pharmacist, advanced care practitioner and developing the nurse roles.

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
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.