

# Care Quality Commission

## Inspection Evidence Table

### Grove House Surgery (1-554568692)

Inspection date: 23 October 2019

Date of data download: 11 October 2019

## Overall rating: Good

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

### Effective

### Rating: Good

#### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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
Explanation of any answers and additional evidence: Staff were alerted to clinical guidance updates through a range of processes, including meetings; ranging from daily huddles, through to weekly multi-disciplinary and monthly whole practice meetings. Daily meetings and weekly multi-disciplinary team meetings are attended by both clinical and non-clinical staff, who discussed support for patients with complex needs. The weekly meetings were conducted in a collaborative manner with a range of staff and organisations present such as; GPs, administrators, nurses, community nurses, health connectors, housing services, and social care.	

The practice holds a monthly training morning, incorporating guest speakers and role-led teaching sessions, where clinical updates and current topics are covered.

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>	0.51	0.66	0.75	No statistical variation

## Older people

## Population group rating: Good

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Named clinicians were responsible for local nursing homes and carried out weekly ward rounds.

## People with long-term conditions

## Population group rating: Good

### Findings

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

- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	71.1%	70.0%	78.8%	No statistical variation
Exception rate (number of exceptions).	6.7% (24)	7.3%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	80.7%	67.4%	77.7%	No statistical variation
Exception rate (number of exceptions).	7.0% (25)	6.2%	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>	79.6%	75.5%	80.1%	No statistical variation
Exception rate (number of exceptions).	12.1% (43)	10.8%	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>	80.4%	61.3%	76.0%	No statistical variation
Exception rate (number of exceptions).	13.9% (61)	7.0%	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>	85.0%	68.8%	89.7%	No statistical variation
Exception rate (number of exceptions).	4.2% (7)	7.2%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QoF)	80.7%	76.2%	82.6%	No statistical variation
Exception rate (number of exceptions).	2.1% (23)	3.7%	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)	86.2%	86.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	1.9% (3)	3.8%	6.7%	N/A

### Any additional evidence or comments

Exception reporting for Asthma.

At the time of inspection, the latest National Quality and Outcomes Framework (QoF) data referred to was for the period 01/04/2017 to 31/03/2018, during which time the practice were not participating in the QoF scheme. Previously, the practice was part of the Somerset Practice Quality Scheme (SPQS) which looked at different quality measures. When the practice returned to using QoF the administration team was restructured to provide additional clinical support, to include an increase in staff with dedicated scanning/coding roles.

The practice acknowledged that the systems and processes for exception reporting did not accurately reflect the numbers of patients who had not received a review of their condition (exception reporting is the removal of patients from QoF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate). We were told that one of the processes for exception reporting had previously been undertaken by an administrator, who would do this if a patient hadn't responded to 3 consecutive recall letters. The practice told us upon return to QoF on 01/04/2019 they have implemented an Exception Reporting Procedure & Policy, which specified that only clinicians could exception report patients from quality indicators.

A few days after the inspection, the most recent QoF data for period 01/04/18 to 31/03/19 was published which records the overall exception reporting rate to be 9.8% which was within an acceptable range.

The practice had in place a system for mitigating risks and we saw that patients who may be at risk of poor control of symptoms were managed appropriately.

### Families, children and young people

Population group rating: Good

#### Findings

- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in

accordance with best practice guidance.

- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	56	58	96.6%	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)	54	61	88.5%	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)	54	61	88.5%	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)	55	61	90.2%	Met 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

Areas that had not achieved target levels were discussed with the practice. This had been recognised and new processes had been implemented within the last few months to improve this, for example;

- Patients were asked to make an appointment rather than being sent an appointment time which had resulted in fewer children not attending for their appointments.
- Children who were non-responders or did not attend appointments were flagged to the health visitors and discussed at the multi-disciplinary weekly meetings.
- The parents/guardians of children were contacted via text message and received a telephone call to discuss the benefits of having their child immunised.
- Children who were persistent non-responders or did not attend appointments were flagged to the health visitors and were also discussed at the multi-disciplinary weekly meetings.
- The nurses had initiated a quality improvement project to improve immunisation uptake.

## 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)	71.7%	N/A	80% Target	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)	72.7%	73.9%	72.1%	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)	58.5%	61.1%	57.3%	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)	69.6%	45.1%	69.3%	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)	32.4%	54.8%	51.9%	No statistical variation

### Any additional evidence or comments

Nurses had identified women who had not attended for cervical cancer screening and telephoned them to discuss the benefits of attending, to allay anxieties relating to the procedure. We were told that women were responding positively to this approach.

Later appointments were available to encourage working women to attend for screening.

**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 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.
- Alerts were put onto a patient's medical record to assist identification of vulnerable patients.

**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.
- The practice works collaboratively with a number of organisations who attend the practice including: Turning Point drug and alcohol service, Citizens Advice, Somerset Talking Therapies, Stop Smoking Group and private counselling 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	54.1%	39.1%	89.5%	Significant Variation (negative)

31/03/2018) <sup>(QoF)</sup>				
Exception rate (number of exceptions).	7.5% (3)	6.6%	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) <sup>(QoF)</sup>	60.5%	47.3%	90.0%	Variation (negative)
Exception rate (number of exceptions).	5.0% (2)	6.0%	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) <sup>(QoF)</sup>	81.5%	52.1%	83.0%	No statistical variation
Exception rate (number of exceptions).	1.5% (1)	6.9%	6.6%	N/A

### Any additional evidence or comments

The practice said that as they had not previously been participating in QoF, their clinical coding was not aligned to QoF coding. The practice showed us unverified data that demonstrated the current rate of Mental Health Care Plans in place to be 78% with an anticipated 100% by year end.

### 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)	474.9	423.2	537.5
Overall QoF score (as a percentage of maximum)	84.9%	75.7%	96.2%
Overall QoF exception reporting (all domains)	3.9%	4.0%	5.8%

	Y/N/Partial
Clinicians took part in 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

An audit was conducted to check the accuracy of the child protection register held within the surgery and to identify where improvements could be made. The audit identified patients where the information held was out of date. Actions were taken by a patients individual GP to update the register appropriately. A follow up audit six months later demonstrated the information on the register was accurate. This meant



that those patients on the child protection register had their concerns discussed in a timely manner which ensured risks to safety were quickly addressed.

A locality quality improvement project had been undertaken to identify patients with high blood pressure to ensure the risks to patients of undiagnosed high blood pressure, such as a stroke, were minimised. Four cycles of the audit were performed over a period of a year. This demonstrated the practice had increased and improved the management of patients with high blood pressure.

## 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:

Nurses undertaking long term chronic disease management had undertaken diploma level courses and the Health Care Assistant had completed NVQ level 3 training. The practice told us one of the Health Care Assistants had received training and support in other clinical areas including; phlebotomy, Vitamin B12 injections, flu vaccinations, coronary heart disease reviews, follow up dressings, spirometry, diabetes checks, blood pressure checks and care planning.

The practice had oversight of all mandatory training, linked to a structured induction and development plan for all staff. Staff were provided with protected learning time.

Continuing Professional Development opportunities were enabled through dialogue with line managers, linked to appraisals.

All staff had an up to date appraisal, except one for which there was a clear rationale and the practice was a GP training practice for GP registrars.

## Coordinating care and treatment

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

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

## 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
Explanation of any answers and additional evidence: Staff encouraged smoking cessation at all opportunities and referred appropriate patients to the local stop smoking service. A dedicated social prescriber, employed by Mendip Health Connections, funded by the Clinical Commissioning Group attended the weekly multi-disciplinary meetings.	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions:	91.6%	89.6%	95.1%	No statistical variation

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>				
Exception rate (number of exceptions).	0.3% (5)	1.1%	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

## Responsive

## Rating: Good

In 2016 this key question was rated as outstanding. Initiatives previously regarded as innovative or unusual rated as outstanding in the past may no longer be so due to a variety of factors for example, things have moved on in Primary Care, whereby what was once considered innovative is now more mainstream or changes to the assessment framework have since been implemented.

### Responding to and meeting people's needs

#### The practice organised and delivered services to meet patients' needs.

	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
Explanation of any answers and additional evidence:	
The practice had initiated a process whereby patients discharged from hospital were followed up via a telephone call by a dedicated member of staff. This was to ensure all social and medical needs were being met to minimise the likelihood of readmission.	
Carers are identified and are seen on the same day if possible.	
The practice recognised the challenges associated with their rural location and accommodated patients with appointment times around transport availability wherever possible. They were also flexible in response to any patient who identified themselves as needing to use public transport to get to the practice.	
Longer appointments were booked for those needing translation services during consultations. Patients requiring longer appointments were identified on their records.	

#### Practice Opening Times

Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 7pm
Wednesday	8am – 7pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Saturday improved access	Saturday mornings, one in five.
Appointments available:	

Monday	8am – 11.20am	3pm – 5.40
Tuesday	8am – 11.20am	3pm – 5.40
Wednesday	7.30– 11.20am	3pm – 5.40
Thursday	8am – 11.20am	3pm – 5.40
Friday	8am – 11.20am	3pm – 5.40
	8am – 11.20 am	3pm – 5.40
Nurses appointments until 18.45 on Tuesdays & Wednesdays		

## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
6469.0	244.0	90.0	36.9%	1.39%

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)	96.8%	95.6%	94.5%	No statistical variation

## 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.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

## People with long-term conditions

## Population group rating: Good

### Findings

- 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 at the weekly multi-disciplinary team meetings.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

## **Families, children and young people**

**Population group rating: Good**

### **Findings**

- Additional nurse appointments were available until 7.45 pm on a Tuesday and Wednesday which school age children could attend so that they did not need to miss school.
- 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 practice provided mother and baby 6 week checks and same day or routine appointments for all children, as well as baby immunisation clinics.

## **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.
- The practice offered early morning appointments once a week and late appointments twice a week to accommodate working age people. Pre-bookable appointments were also available to all patients at additional locations within the area on Saturday mornings, as the practice participated in an improved access scheme.

## **People whose circumstances make them vulnerable**

**Population group rating: Good**

### **Findings**

- 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 allowed patients to use the practice for post relating to their medical needs.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. For example, appointments were offered at the start of clinics to avoid anxiety associated with waiting or a home visit could be offered if necessary.

## **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.

## Timely access to the service

### People were able to access care and treatment in a timely way.

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 absolutely necessary.	Y

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)	96.1%	N/A	68.3%	Significant Variation (positive)
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)	78.1%	70.9%	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 appointment times (01/01/2019 to 31/03/2019)	64.8%	66.3%	64.7%	No statistical variation
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)	81.2%	77.5%	73.6%	No statistical variation

Source	Feedback
CQC comment cards.	31 comment cards were submitted by patients for the attention of the inspection team. All were positive.

## 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.	15
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: The practice has in place a process for recording and managing complaints, via a dedicated complaint review process.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Complaint concerning care received by practice.	One complaint in past 12 months related to a request for an appointment via reception, which the practice acknowledged should have been handled better. Significant event raised by the practice, which was investigated, and actions identified. Areas for improvement included, documentation within medical records and timeliness in contacting bereaved patients. Lessons were taken forward and improvements were made, to minimise the likelihood of reoccurrence and an apology provided to the patient in writing.



## 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:  To address the challenges of increased GP administrative time the practice carried out a work flow quality improvement project. Dedicated staff were trained appropriately to manage and reduce the number of documents that needed to be reviewed by a GP. Processes were in place to ensure maintenance of patient safety, for example, regular audits of documents not reviewed by a GP to ensure that the correct decision had been taken. This had led to optimisation of work flow of medical records and increased GP clinical time.  Staff told us they felt happy and stable working at the practice as part of a one team, open culture and that the leadership was visible and approachable.  The practice had undergone challenges with recruiting staff which has been overcome with the introduction of additional nursing and administration support. We were told that one of the nursing team had recently left the practice and the practice were in the process of recruiting a replacement.	

### 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	Staff told us they felt supported and that the practice was a good place to work. Staff also told us working at the practice was like being part of a family where they felt known by patients and colleagues and where personal development was encouraged. They found senior staff and clinicians to be approachable.

## 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

## 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:	
Risks were effectively managed. For example, we saw the practice had a policy dated 04/03/2019 available on internal computer systems for all staff to access, with a master risk register in place.	
There were appropriate recruitment checks undertaken for new staff, underpinned by a recruitment policy and procedure dated 14/01/2019.	
Staff were aware of safeguarding policies and procedures and were able to give an example as to how these had been implemented.	
All patients discharged from hospital were personally contacted to ensure their medical and social needs were being met to prevent hospital readmission.	

## Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
The practice had invested in software that monitored governance and compliance.	

We saw evidence of statutory notifications having been submitted by the practice to the appropriate authorities, supported by action plans and mitigations to address issues identified and reduce the risk of recurrence.

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

Explanation of any answers and additional evidence:

A range of meetings were facilitated and staff told us they felt able to contribute and make suggestions for improvement. These included:

- Monthly whole team practice meetings.
- Weekly Partner meetings.
- Monthly Monitoring Meetings.
- Monthly training mornings, incorporating guest speakers and role-led teaching sessions.

Feedback from Patient Participation Group.

Feedback
We met with representatives from the PPG who told us the practice worked closely with the Patient Participation Group (PPG) to share information and seek feedback on how to improve services. Meetings were held every six weeks at the practice and the practice manager acted as secretary for the group. Complaints, significant events and feedback from Friends & Family Test results are discussed with the PPG acting as critical friends in seeking to find solutions. The PPG have been active in supporting local health initiatives such as the local ZING exercise programme and park run.

## 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

## Examples of continuous learning and improvement

The practice was working collaboratively with other local practices to improve the management and work flow for patients requiring urgent care. This work included plans to co-locate with the local Minor Injury Unit (MIU), which would provide support for the MIU nurses and a solution to the capacity constraints of practice premises.

The practice had plans in place to become more environmentally friendly using the Green Impact for Health Tool kit to become a climate friendly practice.

## 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. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- 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.
- 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). This indicator does not have a CCG average and is scored against the national target of 80%.

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>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

## 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.