Care Quality Commission

Inspection Evidence Table

Branch End Surgery (1-545581747)

Inspection date: 30 September 2019.

Date of data download: 18 August 2019

Overall rating: Good

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

Effective Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
Explanation of any answers and additional evidence:	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) (NHSBSA)	0.23	0.56	0.77	Variation (positive)

Any additional evidence or comments

The latest data available in relation to this prescribing indicator, for the period 01/07/2018 to 30/06/2019, indicated the practice had maintained a 'variation(positive)', to the England comparison.

Older people — Population group rating: Good

Findings

- All patients had access to 12-minute appointments. Longer appointments were also available when required.
- The practice used a risk profiling tool, to help them identify those patients at greatest risk. The needs of older patients considered to be at risk were discussed during the practice's 'Frail and Elderly' meetings.
- The practice held regular multidisciplinary meetings in line with their meetings programme.
- Arrangements had been put in place to support effective care planning. Emergency health care plans had been completed for those patients considered to be most at risk.
- Older patients were offered opportunities for immunisations as part of the practice's vaccination programme.
- The practice followed up older patients discharged from hospital. Hospital discharge letters were reviewed by GP staff and appropriate action taken, including updating any medicine changes.
- Health checks were offered to patients over 75 years of age.
- Staff had appropriate knowledge of treating older people, including their psychological, mental and communication needs.
- Structured annual medication reviews were carried out. Medicines were only authorised for a maximum of 12-months ahead.

People with long-term conditions — Population group rating: Good

Findings

- Housebound patients could have an influenza vaccination in their own home.
- Practice leads had been identified for the key long-term conditions, to help promote leadership and expertise.
- Staff used the care and treatment templates that were part of the practice's clinical records system. This helped to ensure a more consistent approach to the management of patients'

needs.

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions such as diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation (AF) 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 (AF) were assessed for stroke risk and treated appropriately. The practice was participating in a project to pilot the use of a smartphone, to help screen patients at risk of developing AF.
- Patients with asthma were offered an asthma management plan. The practice was involved in a research project focussing on the needs of high-risk asthma patients. Leaders told us they would be adopting the improvements to practice that had been identified as a result of the research. In particular, improved at-risk patient identification and a 'flagging' alert system to alert staff.
- Where patients with respiratory and/or diabetic needs contacted the practice for a nurse appointment, reception staff would transfer them to the relevant lead nurse.
- GPs followed up patients who had received treatment for an acute exacerbation of asthma at hospital or the local out-of-hours service.
- Clinical staff actively collaborated with other health and care professionals, to deliver a coordinated package of care to patients with the most complex needs.
- Staff who were responsible for reviews of patients with long-term conditions had received relevant training.
- Arrangements were in place to support 'Best-Interest' planning meetings, to help ensure the care preferences of the practice's most vulnerable patients were known and recorded.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	80.4%	83.3%	78.8%	No statistical variation
Exception rate (number of exceptions).	12.6% (28)	16.6%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	74.9%	80.3%	77.7%	No statistical variation
Exception rate (number of exceptions).	8.6% (19)	12.0%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	84.7%	80.7%	80.1%	No statistical variation
Exception rate (number of exceptions).	14.4% (32)	17.5%	13.5%	N/A

Any additional evidence or comments

The latest available Quality and Outcomes Framework data, for 2018/19, indicated that the practice had maintained 'no statistical variation' to the England comparison, for all three of the diabetes indicators. For two of the indicators, the practice had achieved a higher achievement score, compared to the previous year, (last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months/blood pressure reading). For the indicator relating to cholesterol measurement, the practice's achievement score had reduced slightly, and the exception reporting rate had risen.

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) (QOF)	72.4%	75.8%	76.0%	No statistical variation
Exception rate (number of exceptions).	2.2% (8)	8.7%	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) (QOF)	93.5%	91.6%	89.7%	No statistical variation
Exception rate (number of exceptions).	3.8% (3)	13.6%	11.5%	N/A

Any additional evidence or comments

The latest available Quality and Outcomes Framework data, for 2018/19, indicated that the practice had maintained 'no statistical variation', to the England comparison, for the asthma indicator. For the COPD indicator, the practice had achieved a higher achievement score, compared to the previous year, and their performance was now 'tending towards a positive variation' to the England comparison.

The latest available Quality and Outcomes Framework data, for 2018/19, indicated that the practice had maintained 'no statistical variation' to the England comparison, for the hypertension blood pressure indicator. For the atrial fibrillation clinical indicator, the practice had achieved a slightly reduced achievement score compared to the previous year, and their performance now showed 'no statistical variation' to the England comparison. (See below)

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)	81.6%	83.5%	82.6%	No statistical variation
Exception rate (number of exceptions).	2.3% (19)	4.2%	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)	97.6%	85.1%	90.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	10.6% (10)	7.1%	6.7%	N/A

Families, children and young people Population group rating: Good

Findings

The practice:

- Had a designated safeguarding lead who provided expertise and leadership, to help ensure there was a co-ordinated response to concerns about vulnerable patients at risk of harm. Routine meetings, involving health visitor staff, were held to share information about vulnerable children and adults who were at risk. Leaders were planning to introduce a template, for screening vulnerable teenagers, as well as a sexual exploitation risk assessment questionnaire, to help them assess the safety of vulnerable younger people. The senior GP produced occasional safeguarding bulletins, to update staff on changes to arrangements for keeping patients safe. Leaders had devised an 'at a glance' safeguarding bulletin board, to provide their patients with clear guidance about how to raise concerns about vulnerable people. A safeguarding 'corner' had also been set up in the meeting room, to help provide staff with easy access to safeguarding guidance.

- Made use of a local 'red flags' sepsis toolkit, to help provide staff with easily accessible guidance regarding best practice. Staff used a patient information leaflet, to help patients recognise whether their child was seriously ill. The practice had used their social media page to provide parents with information about sepsis.

- Carried out childhood immunisations in line with the national childhood vaccination programme. The childhood immunisation indicators, for vaccines given to children aged two and under, referred to in this evidence table, showed the practice's uptake rates were above the World Health Organisation targets.

- Provided routine ante-natal clinics at the surgery and clinicians also completed the post-natal six-week check for new mothers.

- Had arrangements to identify and review the treatment of newly pregnant women who were on long-term medicines. Leaders planned to run future searches to help identify new patients prescribed this medicine.

- Had arrangements for following up children who failed to attend appointments. Same-day

appointments were available for ill-children, where appropriate.

- Offered family planning advice, including some contraceptive services. Where appropriate, patients were referred to local sexual health clinics. The practice had recently introduced a new template, to help clinical staff safely prescribe the combined oral contraceptive pill.

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)	34	35	97.1%	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)	42	42	100.0%	Met 95% WHO based target
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)	42	42	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	42	42	100.0%	Met 95% WHO based target

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Working age people (including those recently retired and students) — Population group rating: Good

Findings

- The practice's uptake rates for breast and bowel cancer screening, were above the local clinical commissioning group and the national averages. The practice had the second highest screening rates for bowel and breast screening, within the local CCG. They had also performed very well against the national averages.
- The practice's cervical screening rate was slightly below the national average. Cancer Research UK had recently visited the practice, to provide feedback on their performance, and offer advice on other measures they could take, to increase their uptake rate.
- The practice had arrangements in place for informing eligible patients, such as students

attending university for the first time, to have a meningitis vaccination.

- Patients had access to appropriate health assessments and checks, including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcomes, where abnormalities or risk factors were identified.
- Patients could book or cancel appointments and order repeat medication online. Telephone slots were available for medicine reviews, and simple queries and consultations. Plans were in place to increase on-line accessibility.
- Access to extended hours appointments was provided via a local hub. Early hours appointments with a GP or nurse, or for phlebotomy, were provided on a Tuesday.
- Staff made use of a multilingual phrasebook provided by a charity, to help patients whose first language is not English understand the most common medical questions and statements.

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)	78.1%	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)	84.3%	78.0%	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)	72.6%	64.6%	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)	83.3%	67.0%	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)	35.9%	46.7%	51.9%	No statistical variation

Any additional evidence or comments

- Following the inspection, the provider informed us that their cervical screening rates had improved as follows:

  - The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within 3.5 years for women aged 25 to 49, was 81.5%.
  - The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within 5.5 years for women aged 50 to 64, was 83.6%.

  (The above evidence is, however, unverified, unpublished data.)

People whose circumstances make them vulnerable

Population group rating: Good

Findings
• End-of-life care was delivered in a coordinated way, which took account of the needs of those whose circumstances may make them vulnerable. Patients had access to a surgery by-pass number, to provide them with easier access to clinical advice and support. • The practice offered annual health checks to patients with a learning disability, using a standardised template provided by their clinical IT system. Staff actively reviewed vulnerable patients during their routine practice meetings. They actively collaborated with the local community matron, to support their role in reviewing the needs of the practice's more vulnerable patients. • The practice had arrangements in place for vaccinating patients who had an underlying medical condition, in line with the recommended schedule. As part of the practice's preparation for the influenza season, searches were carried out to identify and target 'at-risk' patients. • The practice demonstrated they had a system to identify people who misused substances. • The practice actively signposted patients to local support services, and provided them with relevant information.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings
• The practice provided annual mental health reviews for patients who had a mental illness, and clinicians used these to assess and monitor their physical health. • Leaders and clinical staff worked closely with their secondary care colleagues, to help provide effective care and treatment for patients with mental health needs. • Clinical staff referred patients to local counselling services where appropriate. • The practice's website provided younger patients with access to information about local sources of help and advice. • Patients could access smoking cessation advice at the practice. Patients identified as smokers were offered nicotine replacement therapy products as well as a referral for ongoing support. Data provided by Cancer Research UK, for February 2019, showed the practice's smoking rates were 8%, compared to the local average of 15%. • The practice made use of a dementia toolkit, to help ensure their services were dementia-friendly. Staff had received dementia awareness training. • 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. For patients diagnosed with dementia, clinical staff carried out advanced care planning, and undertook regular reviews.

- The practice followed up patients who failed to collect their prescriptions. The local community mental health team followed up patients who had not attended for the administration of long-term medication.
- The practice was in the process of developing a suicide risk assessment tool, to help clinical staff identify at-risk patients.
- To help provide their patients with a more effective service, leaders were considering how they could provide an in-house psychotherapy service.

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)	94.7%	93.1%	89.5%	No statistical variation
Exception rate (number of exceptions).	5.0% (1)	17.7%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	95.0%	93.9%	90.0%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	12.3%	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)	87.9%	81.7%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.9% (1)	7.0%	6.6%	N/A

Any additional evidence or comments

The latest available Quality and Outcomes Framework data, for 2018/19, indicated that the practice had maintained 'no statistical variation', to the England comparison, for all three of the mental health clinical indicators. There had been a reduction in the practice's achievement score for all three indicators, and the exception reporting rate had risen for the indicator relating to dementia care planning.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care they provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	555.2	550.4	537.5
Overall QOF score (as a percentage of maximum)	99.3%	98.5%	96.2%
Overall QOF exception reporting (all domains)	3.6%	6.1%	5.8%

Any additional evidence or comments
The practice's overall QOF performance, for 2018/19, had risen slightly from 99.3% to 99.7%. QOF exception reporting for all domains remained low, at 3.7%.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Yes
Quality improvement activity was targeted at the areas where there were concerns.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.[1]	Yes

Any additional evidence or comments

- The provider had reviewed their unplanned admissions into secondary care and readmissions data, and had taken appropriate action, to help reduce their rates. They reviewed their own data on a quarterly basis, and that supplied by the local CCG, to determine which patients had undergone unplanned admissions into hospital, as well as the reasons for this. Data shared with us during the inspection, showed the practice's performance placed them in the middle range of reported readmissions rates, when compared to other practices in the local CCG. [1]

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

Clinical audits carried out included:

- An audit to help ensure that patients prescribed long term bisphosphonates (medicines used in the treatment of osteoporosis) underwent regular review. Improvements included:

  - Raised awareness of guidelines and changes to prescribing advice, amongst clinicians.
  - Adding a prompt to alert clinicians to review this type of medicine as part of patients' medication reviews.
  - Where relevant, inviting a small number of patients to attend for a review, to make sure the

medicine was still being appropriately prescribed.
- Stopping this medicine for some patients, to help avoid risks and unwanted side effects.

- An audit to help evaluate clinician's antibiotic prescribing practice for sore throat symptoms, against nationally recognised guidelines. Improvements included:

  - Raised awareness amongst clinicians of the Centor criteria outlined in the national guidance. (The Centor criteria are a set of criteria which may be used to identify the likelihood of a bacterial infection in adult patients complaining of a sore throat.)

  - Provision of feedback to clinicians, where relevant prescribing advice had not been complied with, so they could take steps to improve their practice.

The practice had also carried out a range of other quality improvement activities and were able to demonstrate that patient care and safety had been improved as a result.

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. [1]	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.[2]	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice.	N/A
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes

Explanation of any answers and additional evidence:

- All staff had completed cardiopulmonary resuscitation (CPR). The practice's spreadsheet indicated that CPR training should be updated every 18 months. However, the relevant national guidance states training for clinical staff should be updated every 12 months. We

found that some clinical staff had not updated their CPR training for over 12 months. Staff whose training was overdue were booked to attend sessions on 28 and 31 October 2019. 1

- All staff had completed safeguarding training relevant to their role and responsibilities, with the exception of the two practice nurses, who still needed to complete Level 3 child safeguarding training, as recommended in the Intercollegiate Document, 'Safeguarding Children and Young People: Roles and Competencies for Healthcare staff' (January 2019). Leaders were aware of this and were in the process of trying to source this training. 1
- The practice had supported a member of the dispensing team to complete their nurse training.
- The practice held a monthly in-house training session, to enable staff to complete mandatory training.2

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes

Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
Explanation of any answers and additional evidence:	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	94.7%	95.3%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.8% (11)	0.7%	0.8%	N/A

Any additional evidence or comments
The latest available Quality and Outcomes Framework data, for 2018/19, indicated that the practice had maintained 'no statistical variation' to the England comparison, for the indicator relating to recording the smoking status of patients with specified mental health conditions. The practice's achievement score for this indicator had risen from 94.7% to 96.4%.

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.[1]	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.[2]	Partial
Policies for any online services offered were in line with national guidance.	Yes
Explanation of any answers and additional evidence: • One of the nurses had not completed mental capacity training. Leaders told us they had recognised this shortfall, and the lead GP had planned to deliver additional training for the	

whole staff group. This was shortly due to be provided.

- The practice sought patients' consent appropriately, but did not have processes in place to monitor that consent was being obtained. However, leaders told us:

  - Verbal and written consent was obtained before any minor surgery procedures took place, and documented in patients' medical notes.

  - The practice's clinical IT system included a consent template to alert staff to the need to obtain appropriate consent.

Well-led Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes

Explanation of any answers and additional evidence:

- The provider had increased the size of the GP partnership to include three partners members.

They did this to: help ensure continuity of patient care; develop shared responsibility for decision making; improve staff's motivation to provide patients with high-quality care. They had also recently introduced a tier of middle-management to reduce workload pressures on leadership staff and provide all team members with clearly defined roles and lines of accountability. In addition, the provider had filled vacant salaried GP posts, helping to ensure the continued stability of the practice.

- The practice manager told us they had participated in a mentoring programme, to help develop their leadership skills and knowledge. Leaders had a succession plan to help them ensure the continuing future of the practice.

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.[1]	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes

Explanation of any answers and additional evidence:

- The practice had developed a clear mission statement, with a clear focus on taking steps to provide the highest possible quality of care to their patients. A comprehensive business plan was in place, and arrangements had recently been introduced to help leaders closely monitor the delivery of their business plan, and ensure the quality and safety of the services they provided. Plans had been made to involve representatives from the wider staff group in the practice's new quality assurance committee meetings, to enable more staff involvement in strategic planning. Leaders clearly recognised the importance of involving patients in their planning arrangements. They told us they would do so, once their patient participation group was up and running.[1]

Culture

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

	Y/N/Partial

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

Explanation of any answers and additional evidence:

- The practice had a whistle-blowing policy which included guidance about how to raise concerns, within and outside the practice, and how to access an independent person from the local GP federation. However, the practice manager was uncertain as to whether the policy complied fully with NHS Improvement Raising Concerns (Whistleblowing) Policy, published in 2016. They agreed to follow this up after our inspection.

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

Source	Feedback
Non-clinical staff provided us with feedback	Staff reported: • They knew how to raise concerns and were encouraged to do so. They also said they were told about changes made in response to reported errors. • They were clear about their safeguarding responsibilities, knew how to report a concern and who the safeguarding lead was. • They felt they had a good understanding of how to manage emergencies. • Completion of training was monitored. • Staff had clear roles and responsibilities. • The systems and processes for handling incoming information and test results worked well. • Staffing levels were sufficient, when all posts were filled. • The provider took concerns raised by patients seriously and gave feedback to staff, if this was relevant to their role. • There was a process in place for triaging home visits. • They were not involved in strategic planning. • Protected time was not always available for training.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	N/A

Explanation of any answers and additional evidence:

The practice had:

- Recently set up a new Quality Assurance Committee (QAC) to help them maintain an oversight of all their internal and external reporting and quality assurance needs. Leaders told us the QAC will meet on a quarterly basis and help to ensure that if any concerns are identified, these will be addressed promptly. The provider acknowledged that the new quality arrangements were still in the early stages of development.
- A business continuity plan, to help them respond in an effective way to any unforeseen incident. Clinical staff used a standardised sepsis toolkit, and the senior GP had provided staff with bespoke sepsis training, to help ensure patients received effective care and treatment.
- Effective arrangements for identifying, responding to, and learning from significant events occurring within and, outside of, the practice. Improvements made included: arrangements for making sure any significant events were reviewed during QAC meetings.
- Improved their arrangements for ensuring that their policies and procedures were kept up to date. However, the practice's child safeguarding policy had not been updated, to reflect the latest available national guidance.
- Arrangements in place to respond to safety alerts. Although leaders demonstrated they had taken appropriate action in relation to the safety alerts they received, records confirming this were not always sufficiently clear. We discussed this with the practice manager, who took immediate action to improve their system for recording actions taken in response to safety alerts.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes

A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence:	

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.[1]	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

Explanation of any answers and additional evidence:

- Leaders used performance information such as prescribing benchmarking data, to help ensure their prescribing followed local and national guidelines, and met performance targets and expectations.
- In response to patient feedback, the practice had: made more appointments available; made better use of phlebotomy appointments provided by the local hub.

If the practice offered online services:

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

Engagement with patients, the public, staff and external partners

The practice involved staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.[1]	No
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes

Explanation of any answers and additional evidence:

- Leaders told us that they had previously had a thriving patient participation group (PPG) that had met face-to-face. However, due to difficulties experienced maintaining face-to-face meetings, leaders had made a decision to recruit 'virtual' PPG members, with the hope of attracting new members. Plans were in place to re-start the group. These included: holding health promotion related opening evenings; advertising for new PPG members at the practice and within the local community. [1]

Feedback from Patient Participation Group.

Feedback
• We spoke with a representative of the local dementia group. They told us the practice worked well with them by, for example, sharing information the group gave the practice, with patients affected by the condition.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

Explanation of any answers and additional evidence:

The practice was:

- An approved teaching and training practice and provided training placements for doctors undertaking GP speciality training.
- An active participant in the local, federation-wide, extended hours hub, which provided patients with access to out-of-hours appointments.
- Actively involved in the setting up of the local primary care network.

In addition, staff had:

- Attended quarterly 'time-out' educational training meetings, held by the local clinical commissioning group.
- Taken on additional roles and responsibilities, to help develop their skills and career

opportunities.

Leaders had recently invested in improving the infrastructure of the practice, by providing two new clinical rooms. Infection control arrangements had also been improved. For example, wall mounted soap and alcohol foam dispensers had been installed, and privacy curtains had been replaced by disposal ones. Other building related improvements were planned.

Examples of continuous learning and improvement

- The practice had participated in both the Fundamentals of Change and Productive General Practice (PGP) programmes, to help drive in improvements in care. The implementation of the PGP programme had led to improvements in the practice's scanning and document processing systems.
- The practice was a research practice and had been accredited by the Royal College of General Practice. The practice participated in research, to help improve population health. For example, staff were currently involved in a pilot to help with the early detection of atrial fibrillation. The surgery had been involved in a pilot to use a particular medicine, to help reduce the risk of developing heart disease. Learning included raised awareness amongst clinical staff of the need to make sure patients with chronic kidney disease, were aware of the steps they could take to improve their own health.
- The practice was a pilot practice for the NHS Diabetes Prevention Programme, and continue to be an active promoter of evidence-based behavioural interventions, for individuals identified as being at a high risk of developing type 2 diabetes.
- The practice engaged with the clinical commissioning group's medicines management arrangements, and were currently completing audits relating to polypharmacy and the use of psychotropic medicines, for people with learning disabilities. Improvements included: the creation of a new template for clinicians to use during medication reviews; in-house education events to help clinicians keep up to date with, for example, recent guidelines around high-dose opiates and trying to reduce their use; revision of the practice's medicine review protocol, to include advice on offering longer appointments for patients prescribed four or more medicines.
- The surgery was taking part in a National Cancer Diagnosis Audit.
- Since the last inspection, the practice had strengthened their arrangements for supporting carers. For example, they had updated their new patient registration form, to help patients self-identify when registering with the practice. They had also recently revised and updated their carers policy.
- Staff had reviewed and developed the templates on their clinical system, to help ensure they met the requirements of the practice.
- Leaders ensured learning from significant events was embedded into day-to-day practice. For example, following a significant event relating to the prescribing of the combined oral contraceptive pill, leaders reviewed and updated their prescribing protocol. The relevant clinical template had been updated to reflect best practice and, following a contraception related learning event, the practice introduced a new practice information leaflet and consent form.
- The practice had developed a sepsis information leaflet for patients, to help parents recognise whether their child was seriously ill. They had also used their social media page to provide parents with information about sepsis.
- Following two significant events related to the processing of two-week-wait cancer referrals, the practice reviewed their systems and processes, and made improvements that included the implementation of a new template for all referrals, which automatically sends a 'red flag' to the

secretarial team.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤-3
Variation (positive)	>-3 and ≤-2
Tending towards variation (positive)	>-2 and ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

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

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

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

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

Glossary of terms used in the data.

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