

Care Quality Commission

Inspection Evidence Table

Unity Health (1-556473761)

Inspection date: 27 November 2019

Date of data download: 11 November 2019

Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe Rating: Good

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Staff recognised there were many conditions from dementia to learning disability to frailty to mental health issues that could make a patient vulnerable.	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> The five sites within Unity Health were located across two counties, Buckinghamshire and Oxfordshire. We saw that the practice had established links and named contacts in both areas who they liaised with about any safeguarding concerns. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had an appropriate recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We reviewed four staff files and records for the most recently recruited members of staff during our inspection and saw each contained evidence that appropriate recruitment checks had been undertaken prior to the employment of staff. 	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 12 th and 13 th August 2019	Yes
There was a record of equipment calibration. Date of last calibration: 30 th January 2019	Yes
There were risk assessments for any storage of hazardous substances for example, asbestos and the storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: August and October 2019	Yes
There was a log of fire drills. Date of last drill: July/August/September 2019 (all sites had a fire drill on different dates)	Yes
There was a record of fire alarm checks. Date of last check: October 2019	Yes
There was a record of fire training for staff. Date of last training: At induction and annual update training	Yes
There were fire marshals.	Yes

A fire risk assessment had been completed. Date of completion: April and May 2019 (all sites had an assessment on a different date)	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> We saw that actions from the most recent fire risk assessment had been completed promptly and this had been documented on the action plan. For example, fire signage had been reviewed and replaced throughout the five sites and protective strips fitted around doorways to prevent a fire spreading. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out.	Yes
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had a designated member of staff who managed the premises, facilities and the associated health and safety risks. During the inspection we saw the practice held comprehensive records of completed environmental safety checks and associated risk assessments for each of the five sites. This included various timetables of when the checks and risk assessments required repeating. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: August 2019 & followed up in October 2019	
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The two lead nurses were the infection control leads across all five sites. They had sourced appropriate additional training to support the role. We saw evidence that they had worked with the local Infection Prevention Control Lead from the clinical commissioning group (CCG) and completed site specific infection control audits in August 2019 and reviewed completed actions in re-audits in October 2019. 	

- Unity Health was active within the Royal College of General Practitioners (RCGP) Research and Surveillance network and participated in a national surveillance programme that provided continuous monitoring of infections and diseases in the community as well as RCGP and ethically approved research. The primary purpose of this network was the surveillance of infectious disease.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes

Any additional evidence or comments

- The practice had introduced a clear protocol to support members of the reception team safely manage and triage appointments. We saw this protocol included easily identifiable patient groups, easily-identifiable life-threatening situations alongside deteriorating symptoms.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes

There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.78	0.88	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2018 to 30/06/2019) (NHSBSA)	11.1%	8.9%	8.6%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	6.01	5.93	5.63	No statistical variation
Average daily quantity of oral Non-steroidal anti-inflammatory drugs (NSAIDs) prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	1.14	1.92	2.08	Tending towards variation (positive)

Any additional evidence or comments

We also reviewed prescribing data which was recorded in the Buckinghamshire CCG quality scheme, known as the Primary Care Development Scheme (PCDS). We saw the prescribing data for Unity Health was in line with local targets, for example:

- 85% of patients prescribed NSAIDs and medicines which may led to Acute Kidney Injury Risk had a risk assessment completed, this was in line with the target of 80%.
- 100% of patients prescribed NSAIDs and an anticoagulant had a risk assessment completed, this was in line with the target of 100%.

Medicines management

Y/N/Partial

The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Partial – Point 1
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes

There was medical oxygen and a defibrillator available at all sites and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Point 1 - Staff members were not fully aware of the role and responsibilities of NHS Regional Lead Controlled Drugs Accountable Officer (CDAO). CDAOs are responsible for all aspects of Controlled Drugs management in their region. All organisations within the region are required to report controlled drug incidents and concerns to the CDAO. Blank NHS prescription stationery was stored securely and there was an audit trail in place to monitor usage. However, the prescription stationery did not fully reflect the latest guidance issued by NHS Counter Fraud Agency relating to the security of prescription stationery. To compliment the monthly searches for high-risk medicines, formal six-monthly medicines safety audits were undertaken to monitor actions and outcomes. When actions were identified, these were followed up and discussed with the clinical and dispensary team. 	

Dispensary services (Brill Surgery and Long Crendon Surgery)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Yes
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Partial – Point 1
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Partial – Point 2
Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Yes
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	No – Point 3
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Yes
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Yes
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Yes

There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes
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Explanation of any answers and other comments on dispensary services:	
<ul style="list-style-type: none"> • The practice dispensed to approximately 31% of its patients (6,750 out of 21,705) and dispensed approximately 10,000 items each month. • We saw the practice monitored and reviewed all dispensary near misses, incidents and errors. These were discussed with the dispensary team and any patterns identified and lessons to be learnt were shared. Between November 2018 and November 2019, 117,099 items had been dispensed and there had been 149 near misses, incidents or errors, this equated to approximately 0.1%. • Point 1 - The provider had up to date standard operating procedures (SOP) for the dispensary. However, audits were not carried out to identify non-compliance or support improvements. • Point 2 - Staff members had received appropriate training to work unsupervised in the dispensary. However, they were not competency assessed to ensure they followed policy and procedures. • Point 3 – During the inspection we saw the temperature of one of the dispensary refrigerators had been one degree above the recommended safe temperature range for almost four weeks (27 days). Staff monitoring the temperature had failed to act as per the provider’s own policy or national guidance. This concern was isolated to one refrigerator in one of the sites. We feedback our concerns to the practice and saw an immediate response and instigation of a significant event review. • The refrigerator was decommissioned, all medicines reviewed, and the internal refrigerator temperature was rigorously tested. On review, the practice confirmed that the refrigerator did not display an accurate temperature, for example when tested as part of the significant event review, the temperature reading indicated the temperature reading was higher than the actual true temperature. The practice reviewed the medicines stored within the refrigerator and found the medicines had a 28-day shelf life outside of the refrigerator and the inhalers had a shelf life of three to four months outside of a refrigerator. In line with both patient safety and duty of candour, all patients who may have had affected medicine had been contacted by the practice pharmacist and the situation explained. All patients still had items left to use (so none had exceeded the 28 days when they would continue to be safe for them to use) and the practice advised patients to return any unused items for replacement. We saw all members of staff involved who stored and/or dispensed medicines that required refrigeration had also completed additional training to increase their knowledge and understanding of this important issue. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes

There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	33
Number of events that required action:	33
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Incidents were risk rated, and action plans were developed which were linked to the significant event correspondence. We saw these included dates of completion and referenced evidence of outcomes. • Risk ratings determined if the incident needed to be reported via the National Reporting and Learning System (NRLS). • The practice also celebrated and shared learning from significant events which had been highlighted as positive incidents. • Incidents were discussed at monthly staff meetings, unless remedial action was required sooner. We saw that incidents were reviewed within a specified timescale, unless these were noted for discussion at the practice's annual significant event review meeting. We saw that when incidents were reviewed, updates were added to the significant event form evidencing a clear audit trail. 	

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

Event	Specific action taken
<p>Dispensing error – two medicines with similar spellings.</p>	<p>On collection of their medication, a patient highlighted the wrong medicines had been dispensed. The practice and dispensary team completed a full review, including a review of the contributing factors.</p> <ul style="list-style-type: none"> • Actions taken included a review of adding a potential electronic barcode check into the dispensing process and reducing potential distractions within the dispensary - specifically implementing changes to the dispensary telephone service during peak times to avoid distraction and potential errors being made.

<p>Early sepsis management (a positive significant event)</p>	<p>This incident highlighted a series of positive actions taken by the practice in the management of a patient with sepsis. Highlights included:</p> <ul style="list-style-type: none"> • Joined up working between the GP and practice paramedic. • Responsive and accessible telephone triage, appointment and home visiting systems. • Effective and prompt use of NEWS2 tool (a six-element assessment tool used to standardise the assessment and response to acute illness including sepsis). <p>This incident and successful use of the NEWS2 assessment tool has been reflected upon and shared with all clinicians within the practice to further increase sepsis awareness.</p>
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice used a web-based sharing platform to manage correspondence and communication, this platform included the function to manage safety events/safety alerts. This platform received, recorded and shared the alerts with the GPs who reviewed the alerts, completed the various patient searches and actions when appropriate. We saw these actions were logged to show that non-relevant alerts had also been considered and to show the actions taken following identification of relevant alerts. We saw examples of actions taken on recent alerts for example, sodium valproate (a medicine primarily used to treat epilepsy) and ranitidine (a medicine used to reduce stomach acid production). 	

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:	
<ul style="list-style-type: none">• We saw that regular clinical meetings were held and standing agenda items included new and revised guidance, medicines safety alerts and prescribing updates. We saw meeting minutes were stored electronically and shared for reference and reflection.• The Management Board which included several GP Partners, implemented a strategic effectiveness and clinical effectiveness framework within the practice. This include designating different clinical work streams and clinical responsibilities to different GP Partners with either additional qualifications or specialist interests in that chosen field of medicine. This framework aligned to the British National Formulary which had also been separated into clinical responsibilities and different GP Partners assigned further work streams (the British National Formulary is a pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about many medicines). Staff told us this framework reflected the clinical culture within the practice, outlined clinical processes and created an inhouse directory on who to contact for a specific concern.	

- Staff told us, when lead GPs attended external meetings relating to clinical matters (for example prescribing leads and clinical governance leads' meetings), they would send a comprehensive email to clinicians summarising the salient points and outlining any follow up actions indicated. We saw examples of this and observed that the content was well-written, relevant, and provided clear guidance on any actions required.

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>	0.32	0.55	0.75	Variation (positive)

Older people

Population group rating: Good

Findings

- The practice provided GP services to a local care and nursing home for older people (approximately 16 patients). We spoke with a representative from the home; they praised the practice, the designated GP and the level of 'two-way' communication with the practice to support effective care and treatment and improve treatment for their residents.
- 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.

Findings

- Alongside the Quality and Outcomes Framework (QOF), (a system intended to improve the quality of general practice and reward good practice) the practice worked with the local clinical commissioning group (CCG) and introduced a care and support approach, known as the Primary Care Development Scheme (PCDS), for the care of many long-term conditions. This was a significant shift away from QOF reporting and commenced in July 2017. In April 2019, this was replaced by an amended version of QOF which included elements of both PCDS and QOF and was called QOF+.
- The practices approach to care and support planning was clearly displayed within the practice to educate patients. This included clear diagrams which displayed the 'house of care' and the components required to develop individual personalised care plans for managing long term conditions.
- One of the lead nurses had worked with the CCG to pilot new processes when deciding care delivery for patients with long-term conditions. This work improved the management of care plans for patients with long-term conditions and had been recognised nationally and the nurse had recently received a Queen's Nurse award. A Queen's Nurse is someone who is committed to high standards of practice and patient-centred care. The Queen's Nurse Institute supports innovation and best practice, in order to improve care for patients. The title is available to individual nurses who have demonstrated a high level of commitment to patient care and nursing practice. This award reflected the work of the nurse in supporting patients managing their own long-term condition.
- 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 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. The data submission for PCDS (April 2018-March 2019) indicated 78% of eligible patients were issued a rescue pack. This was in line with the local target of 80%. A COPD rescue pack provides patients with a five-day supply of a corticosteroid and a five-day supply of an antibiotic to support effective self-management of the condition.

- Patients with asthma were offered an asthma management plan.
- The practice had worked with the long-term condition, prevention and support self-care training lead at the local CCG to deliver wellbeing sessions to the practice – this was initially rolled out to staff, prior to patients.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	82.7%	74.7%	79.3%	No statistical variation
Exception rate (number of exceptions).	4.4% (44)	6.2%	12.8%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	79.5%	71.1%	78.1%	No statistical variation
Exception rate (number of exceptions).	4.4% (44)	5.6%	9.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	81.4%	76.1%	81.3%	No statistical variation
Exception rate (number of exceptions).	11.6% (115)	10.6%	12.7%	N/A

Any additional evidence or comments

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. We saw how the clinical team worked together and in unison with the patients to deliver a coordinated package of care. For example, we saw how the practice optimised the management of diabetes and pre-diabetes (pre-diabetes is a health condition that means blood sugar level is higher than normal, but not yet high enough to be diagnosed with diabetes).
- We saw evidence of comprehensive care and support from the point of diagnosis where patients had an appointment with a GP followed by a one-hour consultation with a nurse. This was followed by a variety of appointments during the year, including two appointments (in most cases the same month each year, usually the birthday month). The first appointment was with a health care assistant to record vital diabetes checks (blood pressure, blood tests and a number of other measurements). The second appointment was with either a nurse or a GP, this appointment was designed to focus on patient's current health and wellbeing goals to improve your health.

- Six months following these appointments, patients had a further appointment, to review progress including a review of the blood pressure, blood tests, other measurements and lifestyles changes. We also saw patients were offered further interim appointments with a nurse especially if the patient was being treated with insulin or needed further support and encouragement.
- On reviewing patient records, the Care Quality Commission GP Specialist Advisor saw the impact this approach had and saw many examples of patients controlling their diabetes, this included losing significant weight and stabilising previously uncontrolled blood sugars.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	71.6%	63.7%	75.9%	No statistical variation
Exception rate (number of exceptions).	2.3% (33)	5.2%	7.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	90.3%	76.8%	89.6%	No statistical variation
Exception rate (number of exceptions).	6.2% (21)	6.1%	11.2%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	83.7%	78.4%	83.0%	No statistical variation
Exception rate (number of exceptions).	1.8% (60)	3.0%	4.0%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	92.8%	96.6%	91.1%	No statistical variation
Exception rate (number of exceptions).	4.8% (22)	7.3%	5.9%	N/A

Findings

- The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all four childhood immunisation uptake indicators. The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children’s appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines (for example, sodium valproate). These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Patients could access services for sexual health and contraception. This included self-test kits for chlamydia.
- 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)	206	209	98.6%	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)	212	218	97.2%	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)	214	218	98.2%	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)	212	218	97.2%	Met 95% WHO based target

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

- Nursing staff proactively followed up families that failed to attend for child immunisations. These families received a telephone call to remind them of the benefits of immunisation and an opportunity to immediate re-booking of the appointment.

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 manage many aspects of their health through the practice website, this included options to book or cancel appointments online, view medical records, see test results 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)	79.8%	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)	75.2%	75.7%	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)	62.1%	58.2%	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. (PHE)		-		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)	51.4%	47.2%	51.9%	No statistical variation

Any additional evidence or comments

- During the inspection, the practice presented more recent (unverified data) cervical screening data for January 2019 to March 2019. This data demonstrated the practice was meeting the national target of 80%.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice incorporated recognised general practice core standards from the Royal College of General Practitioners (RCGP) and Marie Curie UK (a national charity which provides care and support to people with terminal illnesses and their families) into the management of Advanced Serious Illness and end of life care. These standards are commonly referred to as the 'daffodil standards' and include quality statements, evidence-based tools, reflective learning exercises and quality improvement steps to coordinate end of life care.
- 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.
- In July 2019, the practice was awarded Armed Forces Veteran Friendly Accreditation by the RCGP. This was in recognition of the practice's commitment to the Armed Forces Covenant and included access to a dedicated clinician who had a specialist knowledge of military related health conditions and veteran specific health services. This was important in helping ex-forces to get the effective care and treatment.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.

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

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	95.8%	63.9%	89.4%	No statistical variation
Exception rate (number of exceptions).	5.0% (5)	5.3%	12.3%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	90.7%	69.1%	90.2%	No statistical variation
Exception rate (number of exceptions).	4.0% (4)	4.0%	10.1%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	77.3%	84.2%	83.6%	No statistical variation
Exception rate (number of exceptions).	7.2% (11)	3.8%	6.7%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	558.9	No Data	539.2
Overall QOF score (as a percentage of maximum)	100%	No Data	96.4%
Overall QOF exception reporting (all domains)	3%	No Data	No Data

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

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

We saw a programme of clinical audit had been undertaken over the last 12 months, this included a variety of two cycle audits. Audit activity was completed following significant events, in alignment to local and national health priorities and also in areas the GPs had specialist interests in, for example:

Direct Oral Anti-Coagulants (DOACs)

This was a two-cycle audit, the first cycle completed in 2018 and repeated in 2019. One of the GPs worked with the practice pharmacist and completed this work due to increasing numbers of patients being prescribed DOAC medication which required monitoring – all DOAC patients require at least an annual blood test, record of weight and some patients require further three monthly or six-monthly testing. The concern was raised that this monitoring may not be being done and the practice had reviewed national data suggesting approximately 10% of DOAC patients were on incorrect doses and poor monitoring.

In 2018, the first cycle of audit highlighted 296 patients were on DOAC medication, 227 patients (76%) had an annual blood test, 278 patients (94%) were calculated to be on the correct dose and 222 patients (75%) had their weight recorded.

Various actions had been completed and new processes set up to effectively manage this cohort of patients – this included a new recall system, implementation of new ‘pop up’ alerts, monthly searches and new patient searches to ensure monitoring compliance.

In 2019, the second cycle of audit highlighted actions had been positive. For example, 345 patients were on a DOAC medication (an increase of 49 patients), 330 patients (98%) had an annual blood test (an increase of 22%) and 328 patients (95%) of patients had their weight recorded (an increase of 20%). Furthermore, 30 patients were now having blood tests every three months, previously testing was annually. The practice concluded this new system of recall and review of DOAC patients had led to increased patient safety and effective monitoring.

As the system had proven effective and the simple to run, other local practices had contacted the practice to assist implementation of a similar monitoring systems. We also saw the practice had discussed this work with the CCG, and the DOAC monitoring system was being considered as part of the latest commissioning of anti-coagulation service across Buckinghamshire.

Any additional evidence or comments

- As a training practice, the practice had a long tradition of using new evidence-based techniques to support the delivery of high-quality care; we saw all staff were actively engaged in activities to monitor and improve quality and outcomes. The practice catalogued all completed clinical audits and they were stored on the web-based correspondence and communication platform available for all staff. Live and historic audits were used as tools for reflection, learning and to monitor effective patient outcomes.

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

Explanation of any answers and additional evidence:

- We noted a good skill mix among the GPs and nursing team with specialist interest and training in paediatrics, female health, diabetes, musculoskeletal medicine, respiratory disease and medical education. We also recognised several GPs had extended roles within the local health economy including work as GP Trainers, GP Educational Supervisors, designated roles within the CCG and one GP was the Vice Chair Profession Development at the RCGP.
- Staff told us the practice provided a supportive working environment where all staff were enabled to flourish and develop, this was in line with the practice's own vision and values. This included supported one of the nurses achieve the Queens Nurse award. We saw staff progression was actively encouraged and supported in terms of time and finance.
- Members of staff were involved in a number of networks to promote joined-up working and the sharing of best practice.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We found care plans were detailed and completed in full at the practice. Therefore, all pertinent information was available to staff outside of the practice involved in patient care. 	

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, flu campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice supported patients to live healthier lives through health promotion and prevention of ill health. We saw the practice promoted and referred into, where appropriate, various local services including both Buckinghamshire specific and Oxfordshire specific services which had projects to help people lose weight, quit smoking, get more active, feel happier or manage their long-term conditions. 	

- During our observations of the waiting area we also saw the practice promoted healthy walks within the community. These included a map of suggested safe walks within the area, the benefits of getting and staying active, improving mental and physical wellbeing, and reducing social isolation.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	94.5%	91.8%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.5% (26)	0.7%	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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • During our discussions with clinicians they confirmed when providing care and treatment for children and young people, they carried out assessments of capacity to consent in line with relevant guidance. We also saw the correspondence the practice used to record written consent for minor surgery. 	

Well-led

Rating: Outstanding

We rated well-led as Outstanding because:

- There was compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. This included the management of the merger of two multi-site practices into one large practice, covering two counties with approximately 21,750 patients across five sites.
- Despite service delivery from five separate sites, there was collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.
- There was a fully embedded and systematic approach to improvement, which made consistent use of a recognised improvement methodology. Improvement was seen as the way to drive performance and for the organisation to learn. There was a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care which were shared locally and nationally.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• The partners and the management board had overseen the merger of two multi-site practices into one large practice, covering two counties with approximately 21,750 patients across five sites. By putting new systems and ways of working in place, and by promoting a culture of embracing change among staff and patients, they had managed to achieve this with minimal impact on clinical outcomes and without having any serious untoward events. Patient feedback remained high, and a number of new initiatives, such as changes to monitoring patients on anti-coagulant medicines, had been established in the first 12 months of the merger with a demonstrable positive impact on patient care. Different members of the team had designated roles and oversaw the merger, allowing GPs time to continue to see patients.• The management structure of the practice had been amended, with the creation of a management board with two partners from each of the merged practices. The management board also included non-voting nurse leads and a manager to create a representative decision-making board with representation from all teams. This structure was under constant review to ensure it was working effectively, the practice was operating safely, risks and challenges were being managed and systems functioning as intended.	

- Clinicians at the practice had lead roles in the local and national care and medical education networks. They had been involved in developing and leading programmes and interventions together with other local services which had led to improved outcomes for patients.
- The practice had been able to invest in staff in a flexible and reactive way. Staff told us leaders in this practice motivated staff to succeed, develop and grow. All leaders within the practice described examples of compassionate and collaborative leadership.
- There was a focus on sustainability and future-proofing.

Vision and strategy

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

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

Explanation of any answers and additional evidence:

- The decision to merge two practices was a proactive and joint decision, designed to safeguard the future of both practices and keep primary medical services within the five towns and villages the sites were located in. The practice advised of five interlinked strengths of the merger – benefits to patients, staff, quality, economies of scale and to be ready for the changes in NHS travel and the GP Forward View.
- Following the merger, the practice developed a united vision, uniting thoughts from all staff groups, all sites and patients to create the Unity Health vision:

“To improve the health and wellbeing of our community and practice teams through a culture of collaboration, inclusivity and compassion.”

- A mission statement had been agreed to deliver the vision and included four elements – listening, empowering, evidence and improvement.
- All staff shared in the vision of the practice and how the values underpinned the work.

- The practice was aware that their main challenges derived from rural deprivation, distance decay, social isolation, cross-border commissioning, lack of transport links and the travelling distance to access secondary care services. They were committed to work with their Primary Care Network (PCN) to influence developments locally.
- We saw clear evidence of the vision and strategy being achieved.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Staff told us that there was a high level of constructive engagement between the practice leadership and with staff and a high level of staff satisfaction. Different members of staff commented on a recent successful staff wellbeing session which included subjects such as healthy eating, managing stress and anxiety. The practice told us this session may soon be rolled out to the patient participation group (PPG) and possibly group wellbeing sessions for patients to attend in 2020. • Leaders within the practice demonstrated a commitment to 'Freedom to Speak Up' and supported staff to speak up and raise concerns about the delivery of services or any other concerns they had – this was included within the whistleblowing policy and through a new initiative called 'elephant in the room'. Different staff rooms and joint offices throughout the five sites had a display, known as the elephant in the room display – this was an informal approach for staff to identify a concern and openly discuss the concern to make improvements. Staff described this as a safe space for conversation and discussion on issues and a useful feedback mechanism to report a concern. Although in the early stages, the practice advised this had already raised issues, protected patients and improved the experience of staff. 	

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

Source	Feedback
Staff feedback (written and verbal)	<ul style="list-style-type: none"> Throughout the inspection, we spoke to staff at three sites and received written staff feedback from other sites. All staff feedback was overwhelmingly positive, staff we spoke with were motivated and enthusiastic about their role and responsibilities at the practice. All staff spoken with, told us the practice was supportive and inclusive and they were provided with opportunities to develop their skills and abilities. Employed clinical staff told us they received clinical supervision and mentoring.
Meetings	<ul style="list-style-type: none"> Meeting minutes showed regular meetings took place across the different departments in the practice. We saw these meetings facilitated the sharing of updates and any changes to practice following significant events, incidents, patient feedback and changes to best practice.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> We saw that the practice had built upon the governance arrangements of the two merged practices to create a united governance framework which used the strengths of all five sites, the skill mix within the teams to review systems and make further improvements in response to changing needs and requirements from patients and commissioners. The practice had divided the overall governance arrangements into five separate strands which were reported to the managing board. Each strand had a designated clinical lead and non-clinical lead, the practice advised this ensured – ‘the right person, did the right thing, at the right time’. There was a meeting structure with agendas that allowed for discussion of all areas of quality improvement. There was an established programme of staff training including mandatory updates. All staff had received their annual appraisals in the last year. Policies and procedures were up-to-date and were regularly reviewed. They were easily accessible on the practice intranet. 	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance. However, the arrangements within the dispensary should be reviewed.

	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There were numerous lead roles throughout the practice, including leads for safeguarding, infection control, medicines managements, health and safety and human resources. • The practice had a comprehensive range of risk assessments that covered all areas of the practice premises and staff working conditions. These were regularly checked and updated as needed. • Nursing staff had lead roles in chronic disease management. • All staff we spoke with understood not only their own role but the roles of others and their responsibilities and boundaries. • However, on our review of the dispensaries we saw little evidence of audits to identify non-compliance or support improvements. Furthermore, although staff members had received appropriate training to work unsupervised in the dispensary. There was little evidence of competency assessments to ensure they followed policy and procedures. Once highlighted to the practice, we saw both internal audits and a system to assess competency had been implemented. 	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group (PPG).	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes

Explanation of any answers and additional evidence:

- In February 2019, Healthwatch Bucks visited one of the sites (Thame Health Centre) and carried out an “enter and view” visit. Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being run from a patient’s perspective and make recommendations where there are areas for improvement. The visit included a report which was positive and included recommendations which the practice had responded to.
- Patient feedback from all sources including a care home which accessed GP services from the practice was consistently positive.
- We saw how the practice united the two PPGs from the merged practices, to create one group with representatives from all five sites. We saw evidence of how the culture and vision of the practice was disseminated within the PPG and the practice said they were “proud” of their PPG and the help that it brought to the practice.

Feedback from the Patient Participation Group

- During the inspection we saw minutes of meetings the practice had with the Patient Participation Group (PPG). These minutes were available for all to see in a designated section of the practice website. We saw examples where the PPG had made recommendations to the practice which had been acted upon.

- Following the inspection, we spoke to the chair of the PPG, they spoke positively of the relationship between the group and the practice. The information the PPG provided aligned to our findings collected during the inspection. For example, both the practice and the PPG told us about the practice newsletter, the PPG survey, agenda items discussed at each meeting and standing item at PPG meetings where individual staff members introduce themselves to the group and their role at the practice – this was known as the “Getting to know Unity Health staff” section of the meetings.
- We also heard how the PPG had evolved and gained new members who brought additional skills to the group – for example, a member had joined who had an extensive healthcare management background and a member had just joined who had special interest and social media presence on subjects such as carers, dementia and Alzheimer’s.

Any additional evidence

We saw the practice promoted the NHS Friends and Family Test at all sites including the website and encouraged all patients to complete. We reviewed the most recent results and saw consistent high levels of patient satisfaction. For example:

- In the three-month period, August 2019, September 2019 and October 2019, 95% of patients (1,563 responses) advised they would recommend the practice to their friends and family if they needed similar care or treatment.

These results were analysed and displayed on the practice website. This included positive comments, areas for improvement and a practice response to address how these areas would be improved.

The results in the NHS Friends and Family Test aligned to the results collected in the GP national patient survey. For example, 91% of patients (147 responses) described their overall experience of this GP practice as good. This was higher when compared to the local average (85%) and national average (83%).

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

Examples of continuous learning and improvement

- The practice was innovative and forward-thinking and proactively embraced change and new technology, recognising the need to adjust and be prepared for new challenges. This included the option for GP video consultations.

- The practice was a training and teaching practice and endeavoured to support the next generation of primary care. There were three General Medical Council GP Educational Supervisors and approval from Health Education England for one of the trainers and the practice as suitable for GP Trainees in Need of Support (TiNoS). We were told of how the practice had helped a trainee in difficulty and delivered a high level of education to support them.
- Staff also had lead roles outside of the practice in the GP Federation, CCG, RCGP and PCN which helped them to deliver the most up to date care to their patients.
- The practice shared audit findings with the CCG and local practices to drive locality improvements. For example, the anti-coagulant monitoring and recall system.
- The practice actively participated in research to enable positive patient outcomes. For example, the practice was active within the RCGP Research and Surveillance network and participated in a national surveillance programme that provided continuous monitoring of infections and diseases in the community.
- The practice was looking for further avenues of innovate support for all groups within the patient population, including awareness of the 'daffodil standards' for end of life patients, the Armed Forces Covenant for patients who were military veterans and support for the LGBTQ community within the five towns and villages the practice serves.

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)	≤ -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. 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.