

Care Quality Commission

Inspection Evidence Table

Dr M Aslam's Practice (1-495180256)

Inspection date: 12 November 2019

Date of data download: 04 November 2019

Overall rating: Requires Improvement

We rated this practice as requires improvement overall because:

- Performance data was lower for patients with long term conditions and those with poor mental health and exception reporting was high for some areas.
- Governance systems were not effective. Improvements were required in relation to quality improvement activity, performance monitoring, recruitment processes, learning from complaints and identification of risks.

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

Effective

Rating: Requires improvement

We rated patients with a long-term condition and people experiencing poor mental health as requires improvement because:

- Performance relating to the level of cholesterol measured in patients with diabetes was lower than local and national averages and had been since 2015.
- Performance for mental health indicators was lower than local and national averages and had been since 2015.

We rated this practice requires improvement for providing effective care for patients because:

- Although there was some quality improvement activity occurring there was limited evidence that it was used to improve the service.
- The practice had no staff records, including training records, relating to a healthcare assistant that they outsourced from another provider.

These areas affected all population groups; therefore, all population groups were rated as requires improvement.

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) (01/07/2018 to 30/06/2019) <small>(NHSBSA)</small>	0.77	0.85	0.75	No statistical variation

Older people

Population group rating: Requires improvement

Findings
<ul style="list-style-type: none"> The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. The practice carried out structured annual medication reviews for older patients. Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. Health checks, including frailty assessments, were offered to patients over 75 years of age. Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires improvement

Findings
<ul style="list-style-type: none"> The performance data for the management of cholesterol and blood glucose in patients with diabetes, had been lower than average for several years. Performance for managing blood glucose levels had improvement for the year 2018 to 2019, however the number of patients exception reported from this indicator was very high. Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. GPs and Pharmacists followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions. The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. Adults with newly diagnosed cardio-vascular disease were offered statins. Patients with suspected hypertension were offered ambulatory blood pressure monitoring. Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

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

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	98.2%	75.9%	79.3%	Significant Variation (positive)
Exception rate (number of exceptions).	35.8% (154)	7.8%	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>	76.8%	74.0%	78.1%	No statistical variation
Exception rate (number of exceptions).	4.0% (17)	6.4%	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>	58.3%	75.3%	81.3%	Significant Variation (negative)
Exception rate (number of exceptions).	6.3% (27)	9.4%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	96.8%	77.7%	75.9%	Significant Variation (positive)
Exception rate (number of exceptions).	10.0% (35)	2.9%	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>	78.6%	89.9%	89.6%	Tending towards variation (negative)
Exception rate (number of exceptions).	19.1% (31)	6.5%	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>	79.8%	80.6%	83.0%	No statistical variation
Exception rate (number of exceptions).	1.9% (20)	2.7%	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>	90.2%	92.6%	91.1%	No statistical variation
Exception rate (number of exceptions).	12.9% (9)	4.5%	5.9%	N/A

Any additional evidence or comments

The practice was aware of lower performance in some areas for patients with a long-term condition. The practice told us that they tried to capture patients opportunistically. The practice were planning on employing a physician's assistant to support the management of patients requiring chronic disease management. We reviewed the practice's performance over time for indicators relating to long term conditions, and found that, for indicators relating to the review of patients with COPD, performance had been lower than average since 2015.

For diabetes indicators relating to managing cholesterol levels, performance had been lower than average since 2015. For diabetes indicators relating to managing blood glucose levels performance had been lower than average between 2015 and 2018. Performance for the indicator relating to blood glucose levels was higher than average for the period 2018-2019, however the number of patients exception reported for this indicator was very high.

The practice told us that they did not routinely exception report patients, unless they met specific conditions. We asked the practice about several areas of high exception reporting and found that this related to new patients joining the practice and an anomaly with the exception reporting system. We have further reviewed this and are satisfied with the explanation provided by the practice.

There was one lead GP and the remainder of clinical staff were regular locums.

Families, children and young people

Population group rating: Requires improvement

Findings

- The practice has met the minimum 90% target for all four childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for any of the 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. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	85	93	91.4%	Met 90% minimum
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)	89	98	90.8%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	92	98	93.9%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	90	98	91.8%	Met 90% minimum

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

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

- Eligible patients to have the meningitis vaccine, attending the practice for other issues were opportunistically offered the vaccination.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health

assessments and checks where abnormalities or risk factors were identified.

- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery. The practice informed us that nursing appointments booked online were often cancelled at short notice. GP appointments booked online were often used for reasons that would be better suited to another type of appointment or with a different healthcare professional.

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)	55.0%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	58.1%	66.0%	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)	45.4%	53.7%	57.3%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	43.9%	62.2%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	39.2%	52.3%	51.9%	No statistical variation

Any additional evidence or comments

The practice had poor uptake for all types of cancer screening tests. The practice informed us that they try to screen patients, who have not accepted the screening invitation, on an opportunistic basis. Performance for cervical screening has remained at the same level for the last three years.

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.

- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.
- There were systems in place to minimise the use of psychotropic medicines for patients with a learning disability and patients diagnosed with autism spectrum disorder (ASD).

People experiencing poor mental health (including people with dementia)

Population group rating: Requires improvement

Findings

- The number of patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses, who had an agreed documented care plan in their record and whose alcohol consumption had been recorded was much lower than average.
- Where reviews had taken place, we found that 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.
- The practice had close links with the local Dementia specialist nurse. The practice supplied a clinic room for the Dementia specialist nurse to run a weekly clinic, for patients of all local practices not just their own.
- The lead GP and the Dementia Specialist nurse had ongoing discussions about patients, shared knowledge and best practice, to improve the care offered to patients. The lead GP and the Dementia specialist nurse completed joint reviews of patients that were difficult to engage.

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	10.5%	87.0%	89.4%	Significant Variation (negative)

31/03/2019) ^(QOF)				
Exception rate (number of exceptions).	1.7% (1)	8.9%	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) ^(QOF)	43.9%	89.3%	90.2%	Significant Variation (negative)
Exception rate (number of exceptions).	1.7% (1)	6.9%	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) ^(QOF)	79.2%	86.0%	83.6%	No statistical variation
Exception rate (number of exceptions).	7.7% (6)	7.4%	6.7%	N/A

Any additional evidence or comments

The practice were planning on employing a physician's assistant to support the management of this group of patients. The practice performance over the last 5 years for patients with schizophrenia, bipolar affective disorder and other psychoses was not consistent, with performance being at 80% or above for some years and lower for others. For the indicator relating to a documented care plan, performance for this indicator was above 90% for the years 2016 to 2017 and 2017 to 2018. For the indicator relating to recording of alcohol consumption, performance was 100% for the year 2016-2017 and 64% for the year 2017-2018.

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	470.7	No Data	539.2
Overall QOF score (as a percentage of maximum)	84.2%	No Data	96.4%
Overall QOF exception reporting (all domains)	6.8%	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.	Partial ¹
Quality improvement activity was targeted at the areas where there were concerns.	Partial ²
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

The practice informed us that the clinical pharmacist had completed an antibiotic audit, however this was not available to view.
The lead GP had initiated an audit on postnatal depression. We viewed a summary of this, however the data related to the first cycle of this audit was not available for us to view.

Any additional evidence or comments

¹ Some quality improvement activity had taken place, but it was not evident how this activity was used to improve patient care.

² There was not an effective system in place to use information to identify areas requiring improvement and create a clear programme or action plan to achieve this.

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.	¹ Partial
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, pharmacists and physician associates.	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:	
¹ The practice outsourced a health care assistant from another provider. The practice did not maintain a record relating to this member of staff, although the practice was involved in assessing competency.	

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.	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	92.4%	95.4%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.6% (10)	0.7%	0.8%	N/A

Any additional evidence or comments

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:	

Well-led

Rating: Requires improvement

We rated the practice as requires improvement for providing well-led care because:

- The systems in place for overseeing the quality of care provided were not effective. In particular some patients with long-term conditions or those who were experiencing poor mental health.
- The systems in place for reviewing, investigating and acting on patient feedback, including complaints, were not consistent. There was limited analysis of themes and trends of patient feedback.
- Governance and clinical oversight required strengthening. There was a lack of quality improvement activity and performance management.

Leadership capacity and capability

There was compassionate, inclusive leadership. However, leaders could not demonstrate that they had the capacity 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.	¹ Partial
Explanation of any answers and additional evidence: ¹ The practice was involved in teaching the new generation of GPs and physician's associates with a view to future staffing. There was no formal succession plan or named successor in place. The practice manager told us that they had a rapid turnover of staff, who were leaving to pursue roles with fewer demands. They said that there were, in recent years, so many more processes and pathways and staff were required to learn and understand them all. They had outsourced aspects of the service where they could, and were considering other areas that could be outsourced, as they felt they lacked the resources and capacity internally, to meet all the demands required of general practice.	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care, however were not effectively monitoring this.

	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.	¹ Partial
Explanation of any answers and additional evidence: ¹ The practice manager had a clear overview of how their different work streams should work and ideas of how to improve efficiencies. However, we found that monitoring was not always effective.	

Culture

The practice culture did not effectively support 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 – informal discussions with staff. Return to work would be managed by HR, but not had anyone. Christmas do.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Partial ¹
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Partial ¹
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.	Partial ²
Explanation of any answers and additional evidence: ¹ The practice had a system in place for the management of complaints, however complaints handling had been split and some complaints delegated to other staff. The practice manager was unable to find the complaints procedure and policy, on the day of inspection, although we were informed that copies had previously been sent to commissioners. The system was not followed by all staff and it was not clear how some complaints had been investigated, what the outcome was, if any learning had occurred and what information had been shared with the affected person. The practice did not have a practice secretary, therefore formal shared meeting minutes were not consistently kept (although the practice manager kept brief hand-written notes). ² The practice manager reported that equality and diversity were discussed at induction. Staff also had access to training via an online provider, however not all staff had completed this. Following our inspection, the practice sent us copies of minutes, for eight meetings, that the practice manager had produced using their handwritten notes. Although complaints were not individually discussed, there was some evidence of raising awareness of trends. The practice also sent us a copy of the complaints policy which they had rewritten. They told us that the practice manager would be taking back the responsibility of all complaints handling and had plans to use an existing computer system template to acknowledge receipt of complaints.	

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

Source	Feedback
Conversations with staff.	Staff told us that they felt supported and able to raise concerns

Governance arrangements

There were clear responsibilities and roles to support governance and management. However, systems of accountability were ineffective which resulted in poor governance.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial ¹
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: ¹ There were governance systems in place, however, some responsibilities had been delegated to both spread the workload and involve other staff in governance. Where some responsibilities had been delegated, there was limited oversight from leaders, that required actions were being completed. Some members of staff had left the practice and their responsibilities had not been reallocated.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial ¹
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Partial ²
There were effective arrangements for identifying, managing and mitigating risks.	Partial ³
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: ¹ There were assurance systems in place, such as: significant events analysis, audit and some peer review, however, we did not have confidence that they were fully effective, as it was difficult to see where changes had been made. ² There was limited audit in place and it was not possible to see if audit led to improved outcomes for patients.	

³ There was some systems in place to manage risk, however, we were not assured on the day of inspection, that risks raised within complaints and other feedback from patients, would be fully identified and mitigating action taken as there was a lack of evidence that identified where learning had been identified and actioned.

Following our inspection, the practice sent us copies of significant events analysis completed after our visit, mostly based on historic complaints and one on an incident occurring after our inspection. Although this evidenced that the practice had responded to this issue, it was not possible to ascertain, whether this was sustainable.

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial ¹
Performance information was used to hold staff and management to account.	Partial ¹
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial ²
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence: ¹ There was limited evidence that performance data was used to improve the service offered to patients and hold staff and management to account. ² When viewing friends and family feedback, complaints and other documents, it was not always clear when these were received, as they were not dated. The business continuity plan required updating, to reflect accurately where prescription stationery could be found.	

	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.	Yes ¹
Explanation of any answers and additional evidence: ¹ There was a system in place, although no unusual access had been identified to date.	

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. However, it was not clear if information received was always acted upon.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial ¹
The practice had an active Patient Participation Group.	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
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Explanation of any answers and additional evidence:
¹ There was some evidence that complaints and other patient feedback was used to improve services. However, we could not be assured that all feedback was used as there was no documented analysis of themes and trends.

Feedback from Patient Participation Group.

Feedback

The patient participation group (PPG) representative told us that they felt listened to, valued and included in the development of the practice. They reported that the practice was open and honest with them, although the practice did not share outcomes of complaints or significant events analysis. The PPG representative told us that the practice and PPG had tentative plans to hold a health event, to proactively encourage health screening.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial ¹
Learning was shared effectively and used to make improvements.	Partial ²

Explanation of any answers and additional evidence:
¹ The practice had taken part in care navigation training. They used an electronic system supplied by the clinical commissioning group (CCG) to support their clinical and prescribing practices. The practice were leading their local primary care network in developing social prescribing activities such as, walking for health.
² There was some evidence within complaints logs of actions taken following complaints investigation. As no formal meeting minutes were kept of staff and clinical meetings, there was limited evidence that learning from complaints and significant events had been disseminated. After the inspection the practice manager sent us meeting minutes created from the practice manager’s handwritten notes. There was still limited evidence of shared learning, although some complaint trends were discussed.

Examples of continuous learning and improvement

The practice had offered a clinic room to the local dementia specialist nurse to hold a clinic. Patients from both the practice and local area could be reviewed in this clinic.

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.