

Care Quality Commission

Inspection Evidence Table

Oldbury Health Centre (1-545900639)

Inspection date: 23 October 2019

Date of data download: 28 October 2019

Overall rating: GOOD

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

Effective

Rating: Requires Improvement

We rated the practice as requires improvement for the Effective key question because the provider was continued to have higher exception reporting than local and national averages and patients on specific high risk medicines had not been monitored.

Effective needs assessment, care and treatment

Some patients' needs were not assessed, and care and treatment was not delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">On reviewing a sample of patients' records we found five patients on a high risk medicine had not been monitored appropriately. Following the inspection, we received an updated policy to ensure	

recommended guidelines were followed in the management of patients on this medicine. The practice had recently employed a pharmacist who had taken up their post since the inspection and was in the process of reviewing the high risk medicine register.

- On speaking with the lead GP we were told that patients sent for investigations were given a follow up appointment and a task was added to the clinical record for the GP as a reminder to contact the patient to ensure they returned for their appointment.

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>	0.93	0.70	0.75	No statistical variation

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice cared for 171 patients at local nursing homes within the locality. Regular visits to the home were provided at least once a week and for those patients nearing end of life more frequent visits were made.
- 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

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met, however exception reporting rates for long term condition indicators were higher than local and national averages.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours

services for an acute exacerbation of asthma.

- The practice shared clear and accurate information with relevant professionals when deciding on 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. Data provided by the practice showed 88% of patients had been reviewed.
- 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>	86.9%	77.8%	79.3%	No statistical variation
Exception rate (number of exceptions).	22.3% (297)	12.3%	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>	77.7%	77.0%	78.1%	No statistical variation
Exception rate (number of exceptions).	15.8% (210)	10.0%	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>	88.0%	78.4%	81.3%	Tending towards variation (positive)
Exception rate (number of exceptions).	18.6% (248)	11.9%	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	74.4%	75.7%	75.9%	No statistical variation

(01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	26.4% (323)	4.3%	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) (QOF)	91.2%	88.2%	89.6%	No statistical variation
Exception rate (number of exceptions).	25.9% (111)	11.2%	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) (QOF)	83.1%	80.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	6.0% (154)	4.4%	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) (QOF)	86.5%	91.4%	91.1%	No statistical variation
Exception rate (number of exceptions).	1.6% (4)	4.4%	5.9%	N/A

Any additional evidence or comments

Exception reporting was highlighted at the previous inspection as being above local and national averages. At this inspection we found the latest Quality & Outcomes Framework (QOF) data still demonstrated higher than average exception reporting. The practice attributed some of the high exception reporting to the 171 beds at local nursing homes they cared for and the complexities of the patients' medical conditions and those near end of life, where patients were on maximum tolerated therapies.

The practice had made changes to their recall systems which included more personalised contacts for patients who failed to attend their appointments, together with information on risks of not attending reviews and managing their conditions more effectively. The practice were also process mapping the recall and contact system to ensure appropriate steps were being followed to encourage patients to attend their appointments.

Families, children and young people

Population group rating: **Good**

Findings

- The practice had met the minimum 90% target for all of the four childhood immunisation uptake indicators. The practice had not met one of the WHO based national target of 95% (the

recommended standard for achieving herd immunity) for none 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)	252	264	95.5%	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)	255	273	93.4%	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)	251	273	91.9%	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)	251	273	91.9%	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

- Cancer screening targets for cervical screening were below local and national averages. The practice encouraged patients to attend appointments and female sample takers were available from 8am and up to 8pm Monday to Friday.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	65.9%	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)	68.9%	64.3%	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)	47.1%	42.2%	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. (01/04/2017 to 31/03/2018) (PHE)	54.2%	65.9%	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)	51.9%	50.2%	51.9%	No statistical variation

Any additional evidence or comments

Patients were encouraged to attend their cervical screening appointments. A total of three appointment letters were sent out before patients were exception reported for failing to attend. Text message reminders were also used to remind patients of their appointments. Female sample takers were available and in to the routine smear invitation, patients were encouraged to book for smears during consultations. Opportunistic screening was also offered to women aged 25 to 64 years who were eligible. Appointments were available from 8am to 8pm Monday to Friday to give patients flexibility and a choice of when they attended.

People whose circumstances make

Population group rating: Good

them vulnerable

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 had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

- On reviewing a sample of patients records we found five patients on Lithium that had not been reviewed appropriately. (Lithium is used to treat the manic episodes of bipolar disorder). Since the inspection we received an updated policy following recommended guidelines on the management of patients on this medicine.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QoF)</small>	98.9%	91.2%	89.4%	Variation (positive)

Exception rate (number of exceptions).	28.3% (36)	14.2%	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)	97.9%	92.2%	90.2%	Tending towards variation (positive)
Exception rate (number of exceptions).	26.0% (33)	11.1%	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)	82.2%	83.3%	83.6%	No statistical variation
Exception rate (number of exceptions).	11.0% (18)	7.9%	6.7%	N/A

Any additional evidence or comments

The practice were aware of their high exception reporting rates and no improvements had been seen since the previous inspection. We were told the practice planned on implementing personalised care plans for all patients and to further strengthen the system for patients who failed to attend their appointments. The practice currently sends out three appointment reminders and excluded patients if they did not attend the third appointment.

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	552.3	549.2	549.7
Overall QOF score (as a percentage of maximum)	98.8%	95.7%	96.4%
Overall QOF exception reporting (all domains)	19.0%	11.0%	10.0%

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

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

- The practice had completed a two cycle audit on patients who were given statin medicines following a myocardial infarction. (also known as a heart attack). Evidence based guidelines showed 90% of patients should be on a statin.
- The first audit reviewed patients who had had a myocardial infarction in the past two years. A total

of 27 patients were identified and 21 of the patients were on statin medicines, which represented 78%. Of the six patients not on a statin, evidence provided showed two patients were intolerant to statins and two patients had dementia. The remaining two patients were reviewed and provided with the appropriate medicines.

- A second cycle of the audit was completed in the past 12 months which showed a further seven patients had suffered a myocardial infarction. Six patients were on the appropriate statin and one patient had been reviewed to ensure they were able to tolerate the medicine.

Any additional evidence or comments

Following a safety alert for a specific medicine and the increased risks during pregnancy, the practice had completed a search on the clinical system to identify patients at risk. Patients identified were reviewed at the practice and provided with information regarding the risks and the need to avoid exposure to this medicine.

Effective staffing

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

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

Explanation of any answers and additional evidence:

- Newly employed staff had received regular reviews, including an induction and a three month review. Regular training of staff was a priority at the practice with both online and face to face training completed regularly.
- The senior nursing team had organised competency reviews of nurses consultations to ensure staff received regular reviews of their work and feedback on their consultations.

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) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We saw evidence to support that regular multidisciplinary meetings took place with community services. This included liaison and joint working with health visitors and district nurses. Safeguarding, palliative and end of life care was discussed in these meetings in addition to vulnerable patients and patients with complex care needs. 	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> All administration/reception staff had completed the first part of the care navigation training. The aim of the training was to provide staff with the skills to effectively navigate patients to local support and provide a coordinated patient centred care. 	

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>	94.9%	95.7%	95.0%	No statistical variation
Exception rate (number of exceptions).	3.6% (160)	0.8%	0.8%	N/A

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Data provided by the practice showed they had completed an audit in 2018 of patients that undergone minor surgery to ensure consent had been obtained prior to treatment. The audit showed 100% compliance. The audit was repeated again in 2019 and showed 100% compliance.	

Well-led

Rating: Good

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The leadership team were aware of the challenges faced within the local community. The practice had a realistic strategy and supporting objectives to respond to these challenges as well as maintaining sustainability.• Staff we spoke with told us the GPs and leadership team were approachable and supportive. Staff said there was a team approach in everything that was done at the practice. There was a team focus on improving patients' care and experiences.• Staff met regularly to discuss any issues or complex cases and to offer and receive peer support.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• There was a mutual vision among the GPs and staff to provide compassionate, patient centred care.• The practice values were to provide leadership, education and partnership and to reflect, respond and act to ensure patients, staff and external stakeholders received clear pathways to achieve improved outcomes.• Staff we spoke with demonstrated clear understanding of the practice vision, value and strategy	

and applied this in their role.

Culture

The practice had a culture which drove high quality sustainable care / 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.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We found staff to be proud about working at the practice. Staff told us they received support from the GP and managers. Staff had clear roles and responsibilities and staff wellbeing was discussed as part of the appraisal process. The practice encouraged staff to report incidents and share learning. Staff said they were well supported when reporting incidents. 	

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

Source	Feedback
Staff	<ul style="list-style-type: none"> Staff told us they felt well supported and able to raise concerns. They felt listened too and part of the team. Support was available when required and the open door policy of the managers and GPs was appreciated as staff felt they could approach any of the management team for advice and help.
GP Registrar	<ul style="list-style-type: none"> Well organised, supportive practice. The GP partners have provided good tutorials to support clinical learning.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had a system to ensure all staff were clear on their roles and responsibilities. Induction plans for new staff were tailored to the individual and there was a clear structure and accountability process in place. Communication was effective and organised through structured, minuted meetings. All clinicians met regularly to discuss work prioritisation and vulnerable patients as well as difficult cases and current events. There was a good relationship with community teams to ensure patients received effective co-ordinated care. There was an open culture and clear learning culture within the practice. The practice encouraged the reporting of incidents, to identify ways in which the practice could continually improve. 	

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Performance and risk were managed by the leadership team. Regular meetings were held to review quality standards were being met and quality and risk was being managed appropriately. These were monitored along with complaints, significant events, safety alerts and governance management processes. The practice had some emergency medicines available, but these did not cover all the recommended medicines for general practice. The practice had risk assessed one medicine that they did not stock and had made an informed clinical decision not to stock the medicine, however following the inspection the practice reviewed this decision and obtained a small supply. The second recommended medicine unavailable, the practice attributed this to a national shortage. 	

Following the inspection the practice assured us they had subsequently obtained a supply of the medicine.

- The practice had undertaken some risk assessments relevant to the provision of clinical care, including infection control and premises risk assessments. There was an ongoing plan in place to continually monitor risk and act on identified actions.
- Governance and performance management arrangements were proactively monitored and updated.
- The practice implemented a system for ongoing reviews to ensure processes were being followed when recruiting new staff, this included a tailored induction plan, appropriate checks, training programme and the continuous monitoring of staff development.
- Incident reporting was integral to learning and improvement. The practice used all safety concerns (incidents and complaints) as a foundation to review and manage all possible risks. The management of risk was demonstrated as a team effort and all the staff were proactive in ensuring risks were mitigated.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The clinical team had an online communication application to share information. This included safety alerts, updates and any other relevant information. • Regular monthly meetings were held to discuss incidents and significant events and share learning to mitigate future risks. • Meetings were held to discuss clinical guidelines and updates and these were shared with the wider team to ensure changes were actioned. 	

Engagement with patients, the public, staff and external partners

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

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

needs of the population.	
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Staff feedback highlighted a strong supportive team was in place. Staff said the leadership team proactively asked for their feedback and suggestions and ideas were discussed at team meetings. • All comments received on the friends and family test were reviewed and shared with staff. • The Patient Participation Group (PPG) was very active and supportive of the practice. The patient participation group (PPG) had 12 in the group. We were told that the group met on average every month. 	

Feedback from Patient Participation Group.

Feedback
We spoke with some members of the patient participation group who told us the practice listen to what the PPG say. The Lead GP keeps the PPG up to date with the latest news from the CCG and primary care network.

Any additional evidence
Following a suggestion by the PPG, partitions had been put in place at the reception desk to offer privacy to patients whilst talking with the receptionists.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice was part of a primary care network and were involved in making service improvements. This included the introduction of clinical pharmacists to support the GPs in reviewing patients' medicines. • A programme of audits was in place to monitor service provision and quality outcomes. 	

Examples of continuous learning and improvement
The practice had reviewed their management model and had implemented a leadership team. This included managers with separate responsibility for areas of service delivery. We were told the benefits of having a range of managers improved the mitigation of risk, improved quality improvement and the management of future service provision.

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.