

Care Quality Commission

Inspection Evidence Table

Luson Surgery (1-582199483)

Inspection date: 11 December 2019

Date of data download: 06 December 2019

Overall rating: Good

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

Effective

Rating: Requires Improvement

The practice was rated as requires improvement at this inspection. This was because performance and achievement data relating to supporting patients with long term conditions was inaccurate. We could not be assured that patients had received appropriate care and treatment.

In addition, we were not assured that all patients with cancer had received appropriate reviews.

Effective needs assessment, care and treatment

Patients' needs were assessed, however records demonstrating that care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools, were not always up to date. We were not assured that all patients were receiving appropriate care and treatment.

	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.	Partial
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	Yes

digital and information security standards.	
Staff had received training and had access to guidance on sepsis and the deteriorating patient.	

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) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	0.98	0.64	0.74	No statistical variation

Older people

Population group rating: Good

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 an 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 medicine 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. • All patients had a named GP who supported them in whatever setting they lived. • GPs carried out a weekly ward round at the local care home which had helped to reduce the need for additional visits and hospital admissions. • Patients had access to a wellbeing advisor who was able to signpost patients to a variety of community groups to help improve their health and better manage their conditions.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- Quality and Outcomes Framework scores showed some negative variations for people with long term conditions. However, more recent data reviewed during our inspection did not demonstrate satisfactory improvement in line with clinical commissioning group averages.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- A blood pressure monitoring machine had recently been funded through a prescribing initiative and this was in a private area of the waiting room for patients to use.
- 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.
- The practice provided a chronic disease, diabetes and respiratory clinics four mornings a week and on a Friday afternoon.
- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as priority.
- Patients suffering with long term illness or undergoing palliative care had treatment escalation plans (TEPS) where appropriate.
- The practice has introduced longer appointments (15 minutes) for patients with long term conditions (LTC) or complex problems.

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) (QOF)	60.6%	70.1%	79.3%	Variation (negative)
Exception rate (number of exceptions).	2.6% (9)	8.0%	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) (QOF)	55.7%	68.5%	78.1%	Variation (negative)
Exception rate (number of exceptions).	2.9% (10)	6.8%	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) (QOF)	71.4%	76.4%	81.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	7.6% (26)	11.1%	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) (QOF)	57.4%	63.5%	75.9%	Significant Variation (negative)
Exception rate (number of exceptions).	0.6% (3)	6.7%	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)	60.4%	74.1%	89.6%	Significant Variation (negative)
Exception rate (number of exceptions).	3.5% (7)	8.1%	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) (QOF)	69.7%	78.2%	83.0%	Significant Variation (negative)
Exception rate (number of exceptions).	3.3% (34)	3.7%	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) (QOF)	91.4%	88.3%	91.1%	No statistical variation
Exception rate (number of exceptions).	7.9% (12)	5.0%	5.9%	N/A

Any additional evidence or comments
Until April 2019 the practice took part in the Somerset Practices Quality Scheme (SPQS) rather than the Quality and Outcomes Framework (QOF). (QOF is a system intended to improve the quality of

general practice and reward good practice). SPQS measured quality and outcomes differently with an emphasis on quality improvement for a reduced number of indicators. Since April 2019 the practice continued to ensure system records of activity relating to a patients' care and treatment, for long term conditions, was up to date. This work was still in progress at the time of inspection and meant evidence to demonstrate positive patient outcomes was limited.

QOF scores showed negative variations for people with the long term conditions of Diabetes, Asthma, Hypertension and COPD.

- During our inspection, we reviewed the most recent data for Asthma. We found some improvement had been made and achievement was more in line with the clinical commissioning group (CCG).
- Since our inspection the practice provided unverified data to evidence the improvements made to patients with long term conditions. For example, 69% of eligible patients with asthma had received a review in the past 12 months and 78% of patients with COPD had received a breathlessness assessment of 78%. Whilst the unverified data demonstrates an improvement, the data is still below national averages
- The practice was aware of the low achievement figures related to diabetes indicators. They had identified that improvements were needed and had put an action plan in place to ensure all patients on the register were contacted and invited in for a review. We saw that each GP had clinical responsibilities assigned to them to ensure that the QOF reporting was correct.
- During this inspection, our specialist advisor reviewed the action plans put in place by the practice to improve QOF reporting and reviewed a sample of patient records. These showed treatment and care plans had been reviewed and any necessary actions required had been taken.
- Patients were only excepted after a process of not responding to invitations and being on the maximum medicine available.

Families, children and young people

Population group rating: Good

Findings

- The practice had not met the minimum 90% target by 0.5% for two of the four childhood immunisation uptake indicators.
- The practice was below the World Health Organisation (WHO) based national target of 95% for all four childhood immunisation uptake indicators.

However, the practice had taken adequate improvement actions to increase the immunisations uptake and engaged with the parent and guardians of the children who had not been vaccinated.

- 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. Chlamydia testing kits were available in the practice entrance.
- Staff had the appropriate skills and training to carry out reviews for this population group.

- The practice provided twice weekly clinics by a male and female GP for students at a local boarding school to ensure their health needs were being met. In addition, they provided rugby concussion assessments for students.
- The practice advised us it was providing a dedicated babies clinic every two weeks on a Thursday where the next immunisation appointment was also arranged.
- We saw that audits were carried out after every clinic to monitor the children who did not attend (DNA) for their immunisation. The nurse would telephone any families who had missed their appointments and re-book these at a suitable time for the family.

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)	64	68	94.1%	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)	51	57	89.5%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	53	57	93.0%	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)	51	57	89.5%	Below 90% minimum
<ul style="list-style-type: none"> • Once children had their first immunisation the nurses made follow up appointments for the child to attend the immunisation clinics to receive the remaining vaccines. • Weekly searches were carried out on the computer system to ensure that letters had been sent to eligible children's parents or guardians, inviting children for immunisations. 				

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

- Performance indicators to ensure patients received appropriate cancer views were lower than the clinical commissioning group and national averages and improvements were required.
- 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.
- A counselling service is provided locally by the Somerset Partnership, which GP's could refer patients into.
- The practice offered appointments and telephone consultations outside of the GPs' normal working hours.
- There was an appointment reminder service for some procedures such as minor 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)	74.3%	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)	77.2%	73.9%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	57.9%	61.1%	57.3%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	35.5%	45.1%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to	59.1%	54.8%	51.9%	No statistical variation

31/03/2018) (PHE)				
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Any additional evidence or comments

The practice had worked hard to increase the uptake of cervical cancer screening and showed us unverified data for women aged 25-49 the uptake had increased to 79% and for women aged 50-64 the uptake had increased to 84%.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- Patients had access to a wellbeing advisor for signposting, support and social prescribing.
- The practice held a register of patients living in vulnerable circumstances including those diagnosed with a learning disability.
- Longer appointments were offered for patients with a learning disability and at a time that suited them.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- Staff had received additional training to support patients fleeing domestic abuse.

People experiencing poor mental health Population group rating: Requires Improvement (including people with dementia)

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. However, access to health checks, reviews, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services required improvement.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice had a carer's champion who signposted carer's to information and support that was available.

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) (QOF)	48.8%	51.5%	89.4%	Significant Variation (negative)
Exception rate (number of exceptions).	6.8% (3)	9.8%	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)	31.0%	55.4%	90.2%	Significant Variation (negative)
Exception rate (number of exceptions).	4.5% (2)	8.5%	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)	60.8%	61.6%	83.6%	Variation (negative)
Exception rate (number of exceptions).	5.6% (3)	6.4%	6.7%	N/A

Any additional evidence or comments

Until April 2019 the practice took part in the Somerset Practices Quality Scheme (SPQS) rather than the Quality and Outcomes Framework (QOF). (QOF is a system intended to improve the quality of general practice and reward good practice). SPQS measures quality and outcomes differently with an emphasis on quality improvement for a reduced number of indicators. Since April 2019 the practice had worked to ensure system records of activity relating to a patients' care and treatment, for long term conditions, was up to date. This work was still in progress at the time of inspection and meant evidence to demonstrate positive patient outcomes was limited.

QOF scores above showed some negative variations for most mental health targets. During the inspection we reviewed the most current data for 2018/19 which showed:

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in their record, had increased from 49% in April 2019 to 53% in December 2019. This was slightly better than the local clinical commissioning group average (CCG) of 52%.
- The practice had plans in place to ensure patients with mental health needs had their care and

treatment plans reviewed. On the day of inspection, our GP advisor randomly selected five patient records. The records showed that clinical reviews for those patients had been completed where required and referrals to secondary care had been actioned appropriately.

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)	369.5	432.2	539.2
Overall QOF score (as a percentage of maximum)	66.1%	75.7%	96.4%
Overall QOF exception reporting (all domains)	3.5%	4%	5.8%

	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

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

- The practice had undertaken quality improvement and audit work. These included annual minor surgery, intra-uterine system (IUS) and cervical cytology. We reviewed audits and saw two cycle audits with better patient outcomes.
- The results of the minor surgery audit showed that of nine minor operations carried out at the practice, all nine patient records had consent recorded and there were no post operation infections.
- Another audit carried out was following the fitting of Nexplanon (a birth control implant). The practice had carried out 24 fittings with 24 patient records having consent recorded and no post operation infections.

Any additional evidence or comments

We saw evidence of audits carried out following prescribing updates, such as, an audit for patients fitted with an Intra-uterine system (IUS) device for the purposes of Hormone Replacement Therapy (HRT). Due to the licence of a certain brand being for four years use only, all patients on this brand were audited.

- Fourteen patients were reviewed by their GP and the results showed: one patient had already had the device removed, two patients had ceased HRT, ten patients required no action and one patient

was changed to a sequential HRT.

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.	Partial
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, 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
<ul style="list-style-type: none"> Two members of administration staff had not received their annual update for infection control training, which did not align with the timescales in the practice policy. The practice understood the learning needs of staff and provided protected time for training. New staff at the practice said they had been provided with sufficient support and induction. 	

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)	Yes

(QOF)	
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
<ul style="list-style-type: none"> The practice ensured end of life care was delivered in a coordinated way which considered the needs of different patients, including those who may be vulnerable because of their circumstances. 	

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
<ul style="list-style-type: none"> The practice had identified 2% of patients as carers. Staff signposted patients and their carers to further information and community and advocacy services. The practice (as part of Somerset clinical commissioning group funding) had a wellbeing advisor to support individuals to gain greater control of their own health and wellbeing. This included signposting to other agencies such as social care and social prescribing. 	

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) (QOF)	82.9%	89.8%	95.0%	Significant Variation (negative)

Exception rate (number of exceptions).	0.9% (16)	1.1%	0.8%	N/A
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Any additional evidence or comments

Until April 2019 the practice took part in the Somerset Practices Quality Scheme (SPQS) rather than the Quality and Outcomes Framework (QOF). (QOF is a system intended to improve the quality of general practice and reward good practice). SPQS measures quality and outcomes differently with an emphasis on quality improvement for a reduced number of indicators. Since April 2019 the practice had worked to ensure system records of activity relating to a patients' care and treatment, for long term conditions, was up to date. This work was still in progress at the time of inspection and meant evidence to demonstrate positive patient outcomes with-in the smoking indicator was limited.

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
<ul style="list-style-type: none"> The practice monitored the process for seeking consent with audits undertaken of the intrauterine device and minor surgery. Where required, consent was obtained and recorded on patient records and we saw that this included a record of assessment and evidence that any relevant risks had been discussed with the patient. 	

Well-led

Rating: Good

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	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

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
<ul style="list-style-type: none">We saw evidence of sustainable planning and of the practice being responsive to patient needs and expectations as the patient population grew.Practice GPs held a personal patient list and a buddy system was in place to ensure continuity of care.	

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
Staff had undertaken equality and diversity training.	Yes
<ul style="list-style-type: none"> Staff we spoke with told us they felt respected, supported and valued. Staff said they enjoyed working with each other and said there were positive relationships between the teams. There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff had received regular annual appraisals in the last year. Staff we spoke with told us they were able to raise concerns and had confidence that these would be addressed. The practice monitored patient feedback and noted that feedback was higher than local and national averages in the GP national survey. The practice showed a satisfaction rate of between 93% and 97%. 	

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

Source	Feedback
Staff interviews.	<p>Staff told us:</p> <ul style="list-style-type: none"> They enjoyed working at the practice and felt the practice manager was very supportive. Relevant training and support was available. They were always able to discuss any changes or concerns with the GPs or the practice manager.

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
As part of this inspection we reviewed governance processes and found:	
<ul style="list-style-type: none"> • There was a clear staffing structure and discussions with staff demonstrated that they were aware of their own roles and responsibilities as well as the roles of colleagues. • Records, meeting minutes, audits and monitoring systems were well maintained and assisted with the governance and management of the practice. • There were comprehensive risk assessments in relation to safety issues. • There were systems in place for monitoring and reviewing complaints and significant events. • The practice had systems in place to receive and respond to medical safety alerts such as those from the Medicines and Healthcare Regulatory Agency (MHRA). • There was an adequate system to review and manage patients on high risk medicines. • Policies and procedures were updated and circulated to all staff. 	

Managing risks, issues and performance

There were clear and effective processes for managing risks and issues. Performance processes were in place but the quality of patient care and treatment outcomes could not assurance due to inaccurate coding within the patient records.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Partial
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
Since April 2019, the practice had joined the national Quality and Outcomes Framework (QOF). (QOF is a system intended to improve the quality of general practice and reward good practice). Leaders had recognised the data which demonstrated performance required improvement. The practice was in the	

process of ensuring system records of activity relating to a patients' care and treatment, for long term conditions, was up to date. This work was still in progress at the time of inspection and meant evidence to demonstrate positive patient outcomes was limited and further improvements were required.

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
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Any unusual access was identified and followed up.	Yes
<ul style="list-style-type: none"> On the practice website there was advice for patients to manage their online repeat medicine request, appointments, and security. 	

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.	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
<ul style="list-style-type: none"> Patient and staff feedback was discussed at the monthly GP partners meetings and any actions were identified for example displaying the patient survey results in the reception area. The practice encouraged feedback from patients via their website and the friends and families survey. 	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> The practice had an active patient participation group (PPG) who met quarterly. New members were being encouraged to join via the website and posters were displayed in the practice.

Any additional evidence
<ul style="list-style-type: none"> We received 17 completed comment cards. All of these were positive about the practice and the staff. Patients told us the care they received was of a high level and the staff were considerate and caring.

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
<ul style="list-style-type: none"> The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. For example, a patient did not receive a call back from a GP after requesting pain killers following a tooth extraction. Following a review of the incident it was found that the GP had issued the prescription but had not called the patient back. The learning from this incident was that all patients to be advised if a call back is necessary. Minutes of meetings across the practice staff team showed that there was a focus on development and improvement and that learning from significant events, complaints, and patient feedback was shared effectively. 	

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.