

# Care Quality Commission

## Inspection Evidence Table

### Carmel Medical Practice (1-591515088)

Inspection date: 3/12/2019

Date of data download: 29 November 2019

## Overall rating: Good

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

### Safe

### Rating: Good

#### Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: The practice liaised with local colleges and invited them to attend safeguarding meetings if appropriate. The practice liaised with students GP practices whilst at University with handovers of relevant issues such as for patients with nut allergies.	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 1/10/2019	Y
There was a record of equipment calibration. Date of last calibration: 16/5/2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 26/7/2019	Y
There was a log of fire drills. Date of last drill: 2/12/2019	Y
There was a record of fire alarm checks. Date of last check: 2/12/2019	Y
There was a record of fire training for staff. Date of last training: 14/8/2019	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 5/8/2019	Y
Actions from fire risk assessment were identified and completed.	Y

<b>Health and safety</b>	<b>Y/N/Partial</b>
Premises/security risk assessment had been carried out. Date of last assessment: 7/8/2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 7/8/2019	Y

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 9/07/2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

## Risks to patients

### There were adequate systems to assess, monitor and manage risks to patient safety.

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

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

## Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	1.02	1.00	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) (NHSBSA)	7.2%	6.6%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract	5.23	5.30	5.60	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
infection (01/04/2019 to 30/09/2019) (NHSBSA)				
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	2.05	2.05	2.08	No statistical variation

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

Medicines management	Y/N/Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Blank prescriptions that were used in printers were logged in to the practice and stored in a cupboard. There was no process in place to log when the prescriptions were taken and by whom. Following identification of this at the inspection the practice implemented a process with a documentation sheet to ensure that serial numbers of prescriptions taken were recorded so that management knew where they had gone and who had taken them.</p>	

## Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	13
Number of events that required action:	13

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

Event	Specific action taken
Discharge information regarding a palliative care patient was scanned into the patient record without being reviewed by a clinician.	Training and awareness to staff of the importance of the relevant clinician reviewing the information in case of any actions necessary to be taken. Further safeguard implemented that the community matron would contact the practice if a palliative care patient did not have any GP input.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: Alerts came into the practice via a central email. Medication alerts are given to the pharmacist. We saw evidence of a matrix detailing all alerts and the action taken by staff. This was shared with all staff.	

## Effective

## Rating: Outstanding

We rated the practice as outstanding as there was a truly holistic approach to assessing, planning and delivering care and treatment to people who had a long-term condition and people who were older and used services. The safe use of innovative and pioneering approaches to care and how it was delivered were actively encouraged. New evidence-based techniques and technologies were used to support the delivery of high-quality care.

### 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.	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.	Y
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

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>	1.00	0.76	0.74	No statistical variation

## Older people

## Population group rating: Outstanding

### Findings

The practice had a higher number of patients in the over 65 and over 75 age group than local and national averages. (Over 65 years practice percentage 23.6% local percentage 19.6% national percentage 17.3% % aged 75+ years practice percentage 11.2% local percentage 8.8%, national percentage 7.8%)



- The practice had recognised the high proportion of older people and applied for funding to recruit two extra members of staff to provide further focus on identifying and treating frailty in the practice population.
- 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.
- One of the GP partners at the practice had a special interest in cardio-vascular disease and held national roles in this area. They could demonstrate that this continuous learning and improvement had a positive impact on improving patient outcomes in this population group.
- The practice had secured funding for research into patients with atrial fibrillation and cardio vascular disease. They had been performing proactive pulse checks for patients who were over the age of 65 for several years and had the highest prevalence of patients with atrial fibrillation in the locality in this patient group.
- In those patients with atrial fibrillation, the percentage of patients who were currently treated with anticoagulation drug therapy (01/04/2018 to 31/03/2019) (NHS Digital) was higher than local and national averages and the exception rate was lower than both local and national averages.
- The practice was able to evidence that due to their interventions and sharing best practice across the Darlington CCG area, the area had the highest prevalence of patients with heart failure but the lowest rate of admission to hospital. A comparison of demographically similar CCGs showed that Darlington CCG had the highest percentage of patients with heart failure who were treated with the correct medication as advised by the National Institute for Clinical Excellence.
- The practice shared their expertise in this area with other practices in the Darlington locality and could evidence the second lowest rates in the North East and Cumbria region of emergency hospital admissions for patients with stroke. The practice was also able to demonstrate the lowest stroke mortality rates in the north east. They could also evidence a high prevalence of atrial fibrillation in every practice in the Darlington area.
- The practice had access to wellbeing facilitators and could refer patients to this service. The service aimed to tackle social isolation, enhance quality of life, promote physical and mental health and encourage and empower independence.

### • Findings

- 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.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- One of the practice nurses had completed an audit on patients with pre-diabetes indicators. This ensured that these patients were correctly coded on the computer system and received monitoring and education. The first audit highlighted that 33% of patients were coded on the computer and the second audit showed that 68% of patients were now coded correctly, a protocol had been introduced and this work was ongoing.
- The practice was a test site for a trial of digital applications for patients with diabetes to provide them with information and education about their condition.
- 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.
- The practice had a long history of identifying patients with cardio-vascular disease, routinely screened patients for atrial fibrillation and had invested in a system that detected an abnormal pulse rhythm via a simple fingertip test. They were proactively screening all patients who were seen at the practice and all clinicians had access to this equipment.
- One of the GP partners at the practice had a special interest in cardio-vascular disease and held national roles in this area. They could demonstrate that this continuous learning and improvement had a positive impact on improving patient outcomes in this population group.
- The practice had successfully bid for funds from the transformation fund and this had been used to implement a new practice-based system to run monthly audits and reviews for patients treated for atrial fibrillation to ensure compliance with medication. Eleven practices had signed up in Darlington and the GP had made educational visits to the practices and had a programme of audit planned.
- They had developed a system and introduced local guidelines to help prevent incidence of stroke in patients with atrial fibrillation and improve treatment, this was in anticipation of a national target for cardio vascular disease and stroke prevention that was due to be introduced in 2020. Patients were prescribed optimum treatment for anticoagulation and the system ensured that patients were taking the correct dose based on weight and renal function. As a result, the practice could demonstrate an 89% detection of people with atrial fibrillation (target for 2029 was 85%) and patients treated with adequate anticoagulation was at 95% (target for 2029 was 90%) - 81% of these were on the correct anticoagulant dose. The practice had moved to prescribe direct oral anticoagulants (DOACS) instead of warfarin as research showed that the time in therapeutic range

was much better controlled. Carmel Medical practice could demonstrate that that they had already exceeded the 10-year public health target for 2029. This programme had been taken up by all the other practices in the CCG in an aim to reduce stroke caused by atrial fibrillation (a major cause of stroke).

- The practice had conducted an audit of patients on anti-coagulant therapy and found 20 patients were on the incorrect dose, a second audit evidenced that no patients were on the wrong dose.
- The practice was an exemplar site for NHSE, a test site for the development of a specification for Cardio vascular disease screening from 2021.
- The practice was part of a scheme to screen patients for familial hypocholesterolemia (Familial hypercholesterolemia (FH) is a common life-threatening genetic condition that causes high cholesterol, untreated, FH may lead to early heart attacks and heart disease) – NHSE target was to get to 25% by 2021. The GP was a lead for academic health sites and used a tool on the computer systems to identify patients at risk. The practice worked with the British Heart Foundation who then reviewed the results and decided if they had the condition. Patients were then referred for genetic testing and screening –the practice was one of the pilot sites. The scheme was supported by the CCG with funding for nursing time to do the screening. All practices in Darlington took part in this research and 630 patients had been identified so far.
- Patients with suspected hypertension were offered ambulatory blood pressure and ECG monitoring. The GP with specialist interest reviewed results from these patients and because of their expertise in this area was able to reduce referrals to secondary care. We saw evidence that 100% of newly diagnosed hypertension patients, age 30-74, with risk of cardio vascular disease were treated with statins, compared to a local figure of 77% and a national figure of 65%.
- The practice was participating in a project and had met with consultants in secondary care to look at the benefits of introducing new medicines to patients with cardio-vascular disease – this was based on evidence.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.
- The practice had monthly visits from the consultant diabetologist and the diabetic specialist nurse to help ensure safe and effective care for the diabetic patients.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	84.1%	82.9%	79.3%	No statistical variation
Exception rate (number of exceptions).	12.3% (75)	14.1%	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	85.6%	78.7%	78.1%	No statistical variation

months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) <sup>(QOF)</sup>				
Exception rate (number of exceptions).	6.6% (40)	9.9%	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>	85.0%	85.0%	81.3%	No statistical variation
Exception rate (number of exceptions).	12.0% (73)	13.1%	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) <small>(QOF)</small>	73.1%	75.1%	75.9%	No statistical variation
Exception rate (number of exceptions).	1.7% (12)	6.5%	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>	80.6%	90.3%	89.6%	Tending towards variation (negative)
Exception rate (number of exceptions).	4.3% (11)	9.4%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	83.9%	85.6%	83.0%	No statistical variation
Exception rate (number of exceptions).	1.9% (35)	3.3%	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>	98.1%	95.1%	91.1%	Variation (positive)
Exception rate (number of exceptions).	3.0% (8)	4.6%	5.9%	N/A

### Any additional evidence or comments

One of the practice nurses who was trained in respiratory disease management had reduced their working hours and this had initially impacted on the amount of chronic obstructive pulmonary disease reviews performed. The practice had acted on this tending toward a negative variation and another member of staff had been trained in respiratory disease management. Unvalidated data from the practice since April 2019 showed that 86% of patients with COPD (195 out of 228 patients) had now had a review and they were actively arranging appointments to review the remaining patients.

## Families, children and young people

## Population group rating: Good

### Findings

- The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of 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)	97	101	96.0%	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)	83	84	98.8%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	83	84	98.8%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	81	84	96.4%	Met 95% WHO based target

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

## Working age people (including those recently retired and students)

Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.</li> <li>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.</li> <li>Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.</li> </ul>

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	82.4%	N/A	80% Target	Met 80% target

to 64). (31/03/2019 to 30/06/2019) (Public Health England)				
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	71.6%	71.4%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	65.5%	59.5%	58.0%	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. (01/04/2018 to 31/03/2019) (PHE)	72.5%	68.5%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	69.5%	61.9%	53.8%	No statistical variation

#### Any additional evidence or comments

The practice was proactive in increasing the percentage of women screened for cervical cancer. Patients were able to access screening at an appointment to suit them in the practice or at weekends or evenings via the extended hours service provided by the federation. The practice had a group learning session to raise awareness of cervical screening in patients with a learning disability.

#### People whose circumstances make them vulnerable

Population group rating: Good

#### Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice 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 had access to a well-being facilitator.

#### People experiencing poor mental health (including people with dementia)

Population group rating: Good

#### Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for



physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.

- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis and the patient and family were given information and advice regarding support they could access. This was in collaboration with Darlington Dementia Action Alliance.
- 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 was participating in a pilot project to help identify cardio-vascular disease in patients with mental health problems.

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>	83.0%	91.9%	89.4%	No statistical variation
Exception rate (number of exceptions).	13.0% (7)	14.1%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	82.7%	92.2%	90.2%	No statistical variation
Exception rate (number of exceptions).	3.7% (2)	12.2%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	74.3%	83.0%	83.6%	No statistical variation
Exception rate (number of exceptions).	11.8% (14)	8.1%	6.7%	N/A

#### Any additional evidence or comments

The local area had problems accessing information from secondary care regarding mental health reviews and the practice had been in talks with secondary care in order to address this. They had set up a register of patients with mental health needs that was closely monitored.

#### 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)	550.2	No Data	539.2
Overall QOF score (as a percentage of maximum)	98.4%	No Data	96.4%
Overall QOF exception reporting (all domains)	4.1%	No Data	No Data

	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

An audit of patients who were prescribed lithium ( a medicine that requires regular blood test monitoring for lithium levels) highlighted improvements could be made to practice procedures regarding contacting patients who were late for a blood test. The practice now contacted patients as well as the secondary care team.

### 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

### 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)	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.	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

## 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

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>	95.6%	95.3%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.4% (12)	0.6%	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

## 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.	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

### 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

## 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.	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

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

Source	Feedback
Staff questionnaires	Staff state that they are a good team and managers and leaders are supportive and approachable.

## 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



## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	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
<p>Explanation of any answers and additional evidence:                      The practice had gone through a period of staff absences due to sickness, maternity leave and retirement, including recent retirement of two senior partners.                      Despite this, we saw that patient care was not compromised and this was corroborated by staff and patients.</p>	

## 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

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Any unusual access was identified and followed up.	Y

## 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 needs of the population.	Y

Feedback from Patient Participation Group.

Feedback
We were told that the Patient Participation Group (PPG) meetings were well set up, if suggestions were made the practice would listen and acted on them. If they were any issues at the practice they discussed the problem with the PPG.

### Any additional evidence

We gained feedback from 35 comment cards and 10 patient questionnaires. 33 comment cards were very positive, 2 were mixed the main issue being cited as waiting times for appointments. Eight questionnaires were very positive, two were mixed again regarding waiting times for appointments.

## 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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a strong history of learning and improvement and was part of numerous initiatives to drive improvements in care for their patients and patients in the wider locality. They actively participated in research and had employed a research nurse to this end.</p> <p>The practice proactively shared learning with other practices in Darlington to ensure that all patients benefitted from their actions.</p>	

### Examples of continuous learning and improvement

- There was a very strong ethos of research to improve outcomes for patients. There was ongoing work in relation to improving the treatment and screening of patients with various conditions, including cardio vascular disease and familial hypercholesteremia. The

practice was part of numerous pilots, including being the UK site for a new medicine in heart disease and hypertension

- The practice was collaborative and open to sharing best practice and had written to all practices in Darlington to gauge interest in research, they had a meeting to restore Darlington research collaborative. This was of great benefit to patients and as all practices in Darlington were on the same computer system patient records could be accessed across all practices. The initial meeting had found that most practices were interested.

## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.