Care Quality Commission

Inspection Evidence Table

West Street Surgery (1-540962306)

Inspection date: 20 January 2020

Date of data download: 16 January 2020

Overall rating: Good

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

Safe Rating: Good

At the May 2019 inspection the practice was rated as requires improvement for providing safe services because:

- **The practice had systems in place to assess risk. However, these were not always effective and remedial works were not consistently being completed.**
- **There was clearer oversight of significant events and safety alerts. However, actions discussed were not always reviewed or completed to ensure learning and improvement.**
- **The systems to ensure infection prevention and control had improved and an audit had been completed and acted upon. However, there were no records of cleaning non-single use items of equipment.**
- **Weekly fire extinguisher checks had not been completed since November 2018 in line with the practice policy.**

At the January 2020 inspection the practice was rated as good for providing safe services because:

- **The practice was compliant with the warning notices issued in May 2019.**
- **The practice had effective systems to manage risk and had comprehensive action plans in place to ensure patient safety. We saw that remedial work and mitigating actions were being conducted.**
- **Significant events, incidents and safety alerts were managed appropriately. We saw that learning was taken from these events and practice improvements were being made.**
- **The practice had developed standard operating procedures and cleaning schedules to ensure infection prevention and control related to non-single use equipment such as nebulisers and spirometry machines.**

- **The practice was completing regular fire equipment checks, including alarm testing and fire extinguisher checks.**

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 ensured that safeguarding policies were accessible to all staff and contained information regarding local contacts and escalation procedures. Staff were able to recognise the signs of abuse and were confident in reporting these.	

Recruitment systems	Y/N/Partial
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
Explanation of any answers and additional evidence: The practice conducted regular checks of professional registrations and kept a log of these. Recruitment files for locums including qualifications, indemnity insurance, references and training were also maintained.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: September 2019	Y
There was a record of equipment calibration. Date of last calibration: September 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: January 2020	Y
There was a log of fire drills. Date of last drill: October 2019	Y
There was a record of fire alarm checks. Date of last check: January 2020	Y
There was a record of fire training for staff. Date of last training: Ongoing	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: December 2019	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: The practice conducted weekly checks of fire equipment including emergency lighting, alarm systems and extinguishers. The fire risk assessment highlighted actions that needed completing. This included regular checks of equipment, the fitting of smoke alarms and a new alarm system. We saw that these actions had been completed and that any additional training needs had been highlighted and conducted.	

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

Explanation of any answers and additional evidence:

The practice had conducted a thorough health and safety risk assessment and had developed a running maintenance log to ensure concerns were resolved. For example, we saw that the practice had identified a trip hazard due to uneven paving and this had been resolved.

The practice had an external legionella risk assessment in July 2018. We saw that the practice had conducted the recommended actions such as regular water temperature checks and flushing of outlets. Remedial works such as replacing the water tanks had been completed. We also saw that appropriate action had been taken when water temperatures were outside of the recommended range.

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: October 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

Explanation of any answers and additional evidence:

The practice had sought support from the local clinical commissioning group and completed a thorough Infection Prevention and Control (IPC) audit. We saw that improvements to the building, such as repairing cracks to the walls, had been completed. The practice had also developed procedures and schedules for the cleaning of non-single use equipment such as nebulisers and spirometry machines. There were outstanding items that had been identified, such as replacing flooring within the cleaning cupboards that were being progressed at the time of the inspection.

The practice provided training for reception staff who managed clinical specimens however, the nursing team had identified that this could be improved and was developing a specific training session.

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

Explanation of any answers and additional evidence:

The practice had developed a locum induction pack with appropriate information. This was signed by locum staff to ensure they had read and understood the contents. The practice used regular locum staff.

The reception staff had received training on identifying patients that were acutely unwell and had signs of sepsis. There were symptom cards at reception desks that could be used as prompts. They felt confident in how to escalate these patients for urgent clinician review.

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
Explanation of any answers and additional evidence: We reviewed four clinical records that showed that referrals were completed in a timely manner and contained appropriate clinical information. We saw documentation of conversations with patients to explain why referrals had been made and the appropriate follow up appointments were booked.	

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)	0.85	0.87	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)	7.5%	8.6%	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 infection (01/04/2019 to 30/09/2019) (NHSBSA)	6.30	5.90	5.60	No statistical variation
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)	3.19	2.14	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.	Y
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	Y

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
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
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:

The practice had developed mentoring sessions for non-clinical prescribers where audits of their consultations were conducted. Any concerns regarding prescribing were discussed with clinicians and competence was assessed. This was completed for all prescribing clinicians, including locum staff on a bi-monthly basis.

The practice had a prescribing lead and clinical pharmacist who monitored prescribing rates. They had developed a protocol for medicines that required additional monitoring and records we checked showed that the appropriate blood testing was being conducted prior to prescribing.

The practice had completed audits regarding antibiotic use in minor illness, such as ear or urinary infections. This was discussed with staff during a clinical meeting and the second cycle audit showed an appropriate decrease in antibiotic prescribing.

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:	37
Number of events that required action:	37
Explanation of any answers and additional evidence: The practice had developed a log of significant events where learning was recorded. We saw evidence of significant events being discussed with staff at regular meetings where practice improvements and actions were recorded and reviewed. The practice also reviewed complaints within this process and highlighted any that also needed to be managed under the practice significant event criteria. Staff we spoke with were confident in raising concerns and received feedback as to how they had been managed.	

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

Event	Specific action taken
An out of date vaccination had been given to a patient.	The patient was informed of the error and an apology was given. The nursing team contacted the manufacturer of the vaccine who assured them that the patient would not suffer any ill effects. All vaccinations were checked and any further out of date vaccinations were destroyed. The nursing team developed a 'fridge map' using magnets to highlight which vaccines were in the fridge and when they would expire. They also ensured that the electronic stock list was updated and kept accurate.
Patient given correspondence with another patient details	Both patients were written to and informed of the error with an apology. This was discussed at a practice meeting where all staff were reminded to double-check any correspondence to ensure the correct patient details were present.

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: The practice discussed all safety alerts within clinical meetings and used the electronic records to highlight patients affected by each alert. We saw examples of actions taken on recent alerts for example, regarding sodium valproate.	

Effective Rating: Good

At the May 2019 inspection, we rated the practice as inadequate for providing effective services because:

- **There was evidence of health checks being completed, however there was an ineffective recall system to invite patients to attend.**
- **There were limited numbers of care plans being completed for those in vulnerable groups.**
- **All staff had received mandatory training and management teams had oversight of training needs. However, there were gaps in GP training, such as dementia awareness training. All GP mandatory training had been completed. There was no evidence of appraisal processes for salaried GP's or clinical pharmacists.**
- **There was high exception reporting in some areas.**

At the January 2020 inspection, the practice was rated as good for providing effective services because:

- **The practice was compliant with the warning notices issued in May 2019.**
- **The practice had strengthened the recall system and we saw that patients were being invited for health checks and follow up appointments.**
- **The practice had identified patients who require a care plan and had systems in place to ensure these had been completed. We saw that an increased number of patients had care plans in place.**
- **All staff had completed the mandatory training set out in practice policies. We saw that all GPs had completed dementia awareness and mental capacity act training.**
- **The practice had developed mentoring sessions for locum and salaried GPs. This fed into appraisal systems.**
- **The practice was aware of high levels of exception reporting in some areas and had put systems in place to ensure all patients received invites for appointments in various ways, including letters, text messages and phone calls. Records we looked at showed that exception reporting was appropriate.**

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
Explanation of any answers and additional evidence: The practice discussed recent guidelines within clinical meetings and utilised electronic tools to ensure this guidance was followed. Clinical records we looked at confirmed this.	

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) (NHSBSA)	1.30	0.81	0.74	No statistical variation

Older people Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with long-term conditions. Those identified received a full assessment of their physical, mental and social needs.
- The practice used a clinical tool to identify older patients who were living with long-term conditions. 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. We saw that the prescribing rate for hypnotics had decreased over the last two years.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group. Housebound patients were visited by practice nurses to offer these vaccinations where appropriate.

People with long-term conditions Population group rating: Good

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.
- The nursing team 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. Regular multi-disciplinary meetings were held with community teams to discuss complex patients.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs where appropriate.
- Patients with asthma and diabetes were offered person-centred care plans and invited to the practice for reviews. These care plans detailed how to contact their named clinician for additional support.
- All blood results that may indicate diabetes were reviewed by the diabetic lead nurse who invited patients in for repeat testing or consultation as appropriate.

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)	85.4%	80.4%	79.3%	No statistical variation
Exception rate (number of exceptions).	17.0% (112)	16.2%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) (QOF)	68.3%	75.9%	78.1%	No statistical variation
Exception rate (number of exceptions).	16.7% (110)	12.7%	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)	82.2%	83.5%	81.3%	No statistical variation
Exception rate (number of exceptions).	15.5% (102)	14.2%	12.7%	N/A
Explanation of any answers and additional evidence: The practice was aware of the high exception reporting in some areas. The practice had changed the exception reporting policy within the last twelve months and this was no embedded into practice to improve these rates in the future. This ensured patients were not excepted too early in the year to allow for additional contacts and opportunistic review. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)				

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)	72.1%	77.2%	75.9%	No statistical variation
Exception rate (number of exceptions).	1.7% (13)	9.3%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	94.1%	90.7%	89.6%	No statistical variation
Exception rate (number of exceptions).	8.6% (19)	14.7%	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)	86.4%	81.8%	83.0%	No statistical variation
Exception rate (number of exceptions).	5.0% (95)	4.9%	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)	96.8%	94.3%	91.1%	Tending towards variation (positive)
Exception rate (number of exceptions).	4.4% (10)	4.0%	5.9%	N/A

Families, children and young people Population group rating: Good

Findings

- The practice was slightly lower than the 90% target for two of the four childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all of the four childhood immunisation uptake indicators. The practice had been proactive in contacting the families of children due to have immunisations several times using different methods. They had identified that there was a proportion of transient families in the area that may remain on the practice register after they had moved away. These patients were discussed with the health visiting team.
- 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. They were referred to maternity services where appropriate.
- 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)	104	110	94.5%	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)	124	139	89.2%	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)	126	139	90.6%	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)	122	139	87.8%	Below 90% minimum

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

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (31/03/2019 to 30/06/2019) (Public Health England)	79.7%	73.0%	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	78.5%	73.0%	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)	58.7%	56.6%	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)	31.8%	60.6%	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)	45.2%	54.7%	53.8%	No statistical variation

Any additional evidence or comments
The practice was aware that they were slightly below the England target for cervical screening uptake, however they were above the local average and had improved on the previous year. The practice had identified that women between the ages of 25 years and 49 years had a lower level of uptake and they were focusing on this demographic. They conducted opportunistic screening and ensured that the recall system was inviting eligible patients. The practice had employed a physician's assistant whose focus was on cancer patients and increasing care planning and review for these patients. We saw that patients on the cancer registers had appropriate care plans in place.

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. Records we looked at confirmed this.
- 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 employed a physician's assistant to conduct palliative and end of life reviews. Records we checked showed that advance care planning conversations were taking place. The practice held regular meetings with palliative community teams to discuss these patients.
- 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. These patients were referred to appropriate services.
- A social prescriber had recently been employed by the primary care network and would be available to the practice patients. This practitioner would be able to signpost patients to local support resources.
- The practice supported vulnerable patients within the community by regularly donating to food banks and providing free sanitary products.

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.
- The practice had put systems in place to ensure patients with depression were offered annual reviews and we saw that the numbers of patients receiving reviews had increased since the last inspection. The practice had fully reviewed this register to ensure that patients that had been recorded as having depression were accurate.
- 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. The practice had commenced and embedded a system of identifying patients with early signs of

dementia by using an electronic tool.

- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	92.5%	91.2%	89.4%	No statistical variation
Exception rate (number of exceptions).	32.2% (19)	17.8%	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)	95.5%	90.1%	90.2%	No statistical variation
Exception rate (number of exceptions).	25.4% (15)	15.4%	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)	78.2%	84.2%	83.6%	No statistical variation
Exception rate (number of exceptions).	7.1% (6)	9.2%	6.7%	N/A

Any additional evidence or comments
The practice was aware of the higher than average exception reporting rates for patients who suffered from mental health conditions. The practice had reviewed the recall system to ensure that patients were receiving invites to the practice using various communication methods. Records we looked at showed that patients were being exception reported appropriately. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

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)	545.3	540.3	539.2
Overall QOF score (as a percentage of maximum)	97.6%	96.7%	96.7%
Overall QOF exception reporting (all domains)	5.7%	6.4%	5.9%

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

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

The practice was involved in auditing the quality of care in order to drive improvements. We saw evidence of audits regarding staff competency and consultation, patient satisfaction, patient safety and infection prevention and control.
The practice had completed two cycle audits that had improved the appropriate use of antibiotics.
The practice had developed a cycle of clinical audits based on patient safety alerts, for example, the use of cholesterol medicine or anticoagulation medicine. The results of these audits were shared with the staff team during clinical meetings. These audits had been repeated and showed improvement in the rates of prescribing.

Effective staffing

The practice was able 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.	N/A
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

All staff had completed the practice mandatory training programme. The management teams had oversight of this. Protected time was offered to complete this training. Staff were offered opportunities to complete additional training to increase their competence in specialist areas.

The system of appraisals allowed for the discussion and development of learning objectives for each staff member. Staff we spoke with told us that appraisals were supportive of their development and career progression.

The practice had developed competency and monitoring systems to ensure oversight of consultations, prescribing and treatment. We saw that this fed into clinical supervision and any concerns were discussed with staff.

There was a clear approach to staff performance and personnel files we reviewed showed evidence of induction and probationary reviews.

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y

Explanation of any answers and additional evidence:

The practice held multi-disciplinary meetings on a monthly basis where all community teams, such as district nurses, community matrons and Macmillan nurses were invited to discuss complex patients. We saw minutes of these meetings were clear and thorough. These were shared with staff who were unable to be at the meetings.

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence: We saw self-care information and posters for national campaigns in the waiting area.	

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)	95.3%	94.7%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.6% (19)	0.8%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence: Records we looked at showed that consent was sought and recorded appropriately. Staff had good knowledge of Gillick and Fraser guidelines. Gillick competence is concerned with determining a child's capacity to consent. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.	

Caring Rating: Good

At the May 2019 inspection we rated the practice as requires improvement for proving caring services because:

- **The practice held a carers register and had begun identifying carers however, the number of identified carers was lower than 0.5% of the practice population. The practice was signposting carers to appropriate community support.**

At the January 2020 inspection we rated the practice as good for providing caring service because:

- **The practice had identified 1.8% of its practice population as carers. The practice utilised local carers resources to share information with patients.**
- **Patients told us they were treated with kindness and compassion.**

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

CQC comments cards	
Total comments cards received.	24
Number of CQC comments received which were positive about the service.	18
Number of comments cards received which were mixed about the service.	5
Number of CQC comments received which were negative about the service.	1

Source	Feedback
CQC comment cards	Many comment cards were positive regarding the level of care from both clinical and administration staff. They reported that staff were kind and put them at ease.
CQC comment cards	Some comment cards mentioned difficulty in getting appointments, difficulty seeing particular GPs or appointments running late.
Patient interviews	Patients we spoke with told us that staff listened to them and treated them with care. No patients we spoke with had any concerns regarding the service provided.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
12141.0	283.0	119.0	42.0%	0.98%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	77.7%	87.8%	88.9%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	75.7%	84.9%	87.4%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	95.3%	95.1%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	74.6%	79.3%	82.9%	No statistical variation

Any additional evidence or comments
The practice was aware of the GP patient survey results and had created an action plan to improve the indicators that were lower than average. This included discussion in practice meetings and utilising the Patient Participation Group (PPG) to repeat patient surveys. The practice had made changes to how plans and treatment was planned for patients and they anticipated that this would improve patient satisfaction. The practice patient survey completed in September 2019 indicated that 83% of patients had the opportunity to raise concerns within consultations.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: Easy read and pictorial materials were available.	

Source	Feedback
Interviews with patients.	Patients we spoke with told us that clinicians explained any treatment changes to them and they felt listened to. They also told us that they had the opportunity to discuss more than one complaint at each appointment.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	91.8%	93.1%	93.4%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 222 patients as carers which equated to 1.8% of the patient population.
How the practice supported carers (including young carers).	The practice had developed a carers pack where patients were signposted to resources. The practice also invited local support groups into the practice on a monthly basis to share information.
How the practice supported recently bereaved patients.	The practice produced leaflets to support bereaved patients.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive Rating: Good

At the May 2019 inspection the practice was rated as inadequate for providing responsive services because:

- **The practice had more oversight of complaints however, was not consistently learning from them.**
- **There was a lack of identification of significant events from some complaints received and a lack of actions taken.**
- **The practice did not have an action plan in place or improvements made to address areas of low patient satisfaction in the national GP patient survey. The practice did not carry out its own patient surveys to collect feedback.**
- **Patients told us that some GP sessions often started late.**

At the January 2020 inspection the practice was rated good for providing responsive services because:

- **The practice was compliant with the warning notices issued in May 2019.**
- **The practice had maintained oversight of complaints and improved practice following these.**
- **We saw that complaints that were also significant events were managed under both processes to ensure discussion and learning was taken from them.**
- **The practice had developed an improvement plan following the GP patient survey. They had carried out their own patient feedback activities to ensure the changes made had been effective.**
- **The practice monitored when staff logged in to ensure sessions always began on time. They had also developed systems to make patients aware if appointments were running late.**

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am – 7.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 7.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday – Friday	Pre-bookable, telephone and on-the day appointments available.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
12141.0	283.0	119.0	42.0%	0.98%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	93.0%	94.2%	94.5%	No statistical variation

Older people — Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived. The practice supported several care homes and conducted regular visits and ward rounds.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

People with long-term conditions — Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment. Patients we spoke with told us they had enough time to discuss all their needs and concerns.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services. Long-term conditions were largely managed by the nursing team who had appropriate training to support this patient group.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services. We saw that advance care plans were in place where appropriate.

Families, children and young people — Population group rating: Good

Findings

- The practice provided baby immunisation clinics with both scheduled and opportunistic appointments to provide vaccination according to the recommended schedule.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice provided an in-house service for sexual advice and contraception.
- The practice hosted a community midwife clinic on a regular basis.

Working age people (including those recently retired and students) — Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. This included online booking systems, electronic prescribing and telephone consultations.
- The practice had recently joined with five local practices to create a community interest company and provide an extended access service.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers. The practice had identified that a proportion of its population were transient and ensured these people were supported and referred as necessary.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. This included longer appointments or home visits when necessary. These patients are now offered annual reviews and care plans.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health. These could also be lengthened where needed.
- Priority appointments were allocated when necessary to those experiencing poor mental health. These could also be lengthened where needed.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. All patients with newly diagnosed dementia are offered a review with the nursing team. All staff had received dementia training.
- The practice was aware of support groups within the area and signposted their patients to these accordingly. We saw posters of local resources within the waiting area.
- A mental health link worker offered a weekly clinic at the practice. They proactively followed up patients who did not attend their appointments. The mental health link worker was qualified to complete medication reviews.

Timely access to the service

People were able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence: The practice had put systems in place to ensure patients were aware that appointments were running late. This included sending messages to reception staff and notices on screens in the waiting areas. Most patients we talked to told us there were minimal delays to appointments.	

Indicator	Practice	CCG average	England average	England comparison
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 (01/01/2019 to 31/03/2019)	55.2%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	55.0%	63.1%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	60.5%	60.2%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	62.5%	70.3%	73.6%	No statistical variation

Any additional evidence or comments
The practice was aware of the lower than average patient satisfaction scores regarding access to the practice via the telephone. They had created an action plan to address all indicators that were lower than local averages. The practice had employed further clinicians and re-trained reception staff in signposting to allow increased availability of appointments. The practice had also installed an improved telephone system following an audit of calls not getting through to the practice. This has increased the number of lines into the practice and allowed the practice to monitor calls waiting to ensure they were answered. The practice had conducted a survey that showed increased patient satisfaction and had plans to repeat this once the telephone system was embedded.

Source	Feedback
Patient Interviews	Patients we spoke with told us that there could be some difficulty gaining access to the practice via the telephone when it first opened but later in the day access was easier.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	38
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: Complaints were logged in order for themes to be analysed. We saw that complaints were discussed at practice meetings to identify learning and improvements. Verbal complaints were also included within this log. We saw that actions and improvements made following complaints were reviewed to ensure completion.	

Example(s) of learning from complaints.

Complaint	Specific action taken
The practice had identified a theme in complaints regarding telephone calls not being answered.	The practice conducted an audit into telephone calls and saw that the telephone system was not always alerting reception staff to the call that was waiting. The practice had installed a new telephone system that allowed patients to be diverted to relevant teams and reception to be aware of callers that were waiting.
A patient experienced an adverse reaction following the prescription of a medicine.	The patient and their carers were invited in to discuss the support that the practice could offer. The clinical records of the patient did not detail any allergies; however, clinicians were reminded to be vigilant when prescribing medicines that could cause reactions.

Well-led Rating: Good

At the May 2019 inspection the practice was rated as inadequate for providing well-led services because:

- **There was ineffective leadership, governance and management structure.**
- **Some staff told us they felt disempowered and unsupported in their roles. Some staff told us that although support and communication had improved, it was still not sufficient.**
- **Staff were unaware of the practice vision and values.**
- **Policies and procedures had been reviewed however, these had not been communicated to all staff.**

At the January 2020 inspection the practice was rated as good for providing well-led services because:

- **The practice was compliant with the warning notices issued in May 2019.**
- **Leadership and governance had improved, and management teams had oversight of processes, staff performance, risks and incidents.**
- **Staff told us that they felt supported and confident to raise concerns. We saw that the practice had put regular meetings and communication structures in place.**
- **Staff were aware of the practice vision and felt involved in the improvements to the practice.**
- **Policies and procedures had been communicated to staff and were embedded into practice.**

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

Explanation of any answers and additional evidence:

The practice had reviewed all systems and processes within the practice to ensure these were effective. Any changes had been communicated to staff through regular meetings, including daily lunch time meetings.

Staff told us that all management staff were approachable. They felt comfortable in raising concerns and confident they would be addressed.

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: The practice had created improvement plans to achieve a high level of care and practice management. These were discussed at practice meetings where progress was monitored. Staff we spoke with were aware of the vision of the practice and felt involved in the improvement plans and achievements.	

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

Explanation of any answers and additional evidence:

The practice culture was open and honest. Staff we spoke with told us that management teams now had an open-door policy and they were available and visible if support was needed.

The practice appraisal and clinical supervision programme allowed staff the opportunity to raise concerns and discuss their development.

We saw that the practice had developed a range of meetings to ensure communication was clear and effective. These included daily lunch time meetings that allowed for informal discussion, training and sharing of ideas. The team was cohesive and worked together to improve practice.

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

Source	Feedback
Staff interviews	Staff were proud to work at the practice and had taken ownership of areas of improvement. They told us they felt supported and communication was effective.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: The practice had a clear management structure in place and had reviewed governance arrangements. We saw that management teams had oversight of risks, staff performance and incidents.	

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
Explanation of any answers and additional evidence: The practice had a comprehensive system of risk assessment including fire, health and safety and infection control. Identified actions were being completed. The practice had completed audits of systems where concerns had been identified, such as telephone access, and had put improvement measures in place.	

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
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: The practice had oversight of clinical and patient satisfaction indicators. Action plans had been developed where necessary to improve these indicators. We saw that the practice used this data to benchmark against local and national averages to drive best practice.	

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
Explanation of any answers and additional evidence: The practice had an active Patient Participation Group (PPG) who met on a quarterly basis. They had been involved in the improvements within the practice and supported the practice with gaining patient feedback by completing surveys. The PPG were also involved in ensuring waiting room notice boards were kept up-to-date.	

Feedback from Patient Participation Group.

Feedback
The PPG found their meetings helpful and informative. They told us they had increased the amount of involvement they had in the practice and were involved in improvements. For example, they had been involved in conducting patient survey and improving notice boards.

Continuous improvement and innovation

There were evidence of systems and processes for learning and continuous improvement.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: The practice used audits and action plans to improve patient care and staff wellbeing. These were regularly discussed in practice meetings and staff had specific roles and responsibilities to ensure actions were completed. There was clear oversight of significant events, incidents and complaints and learning taken from these was shared with staff on a regular basis.	

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 practices 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.