

# Care Quality Commission

## Inspection Evidence Table

### Leeds Student Medical Practice (1-541964802)

Inspection date: 27 February 2020

Date of data download: 24 February 2020

## Overall rating: Good

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

### Effective

**Rating: Good**

#### Effective needs assessment, care and treatment

**Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
Explanation of any answers and additional evidence: Clinicians had direct electronic access to up-to-date guidance, such as that issued by the National Institute for Health and Care Excellence (NICE). The practice delivered contraception and sexual health care and treatment in line with guidance issued by the Faculty of Sexual Health and Reproductive Healthcare (FSRH) and the British Association for Sexual Health and HIV (BASHH). Guidance was discussed within practice and clinical meetings to ensure all staff were aware.	

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) (01/01/2019 to 30/11/2019) (NHSBSA)	0.16	0.57	0.72	Significant Variation (positive)

## Older people

## Population group rating: Not rated

Findings
<p>This population group includes patients who are aged 65 years and over. At the time of our inspection the practice had three patients aged between 65 to 75 years and one patient aged 75 or over. Therefore, a rating has not been given for this population group.</p> <p>We saw evidence that the clinicians at the practice had the skills and abilities to manage older people, should patients choose to register with the practice. However, the practice's registration criteria was to only allow university students and their dependants (of any age), who were living at the same address, to register with the service.</p> <p>The older patients who are registered with the practice are contacted individually and offered vaccinations suitable for their age, such as influenza and pneumonia. Checks of their health and medication reviews are carried out as appropriate.</p>

## People with long-term conditions

## Population group rating: Good

Findings
<p>The care provided for patients with a long-term condition had a different focus to the majority of general practice settings. The practice predominantly managed conditions such as diabetes, pre-diabetes and coeliac disease. However, we found that other long-term conditions were also managed appropriately.</p> <p>The practice had taken steps to improve care for diabetic patients. Additional support was offered to students when transitioning from paediatric to adult care services. Patients could access an appointment at the practice with a diabetic nurse specialist. The practice had negotiated with local services to try and improve support for patients with a structured education programme.</p> <p>Patients who were university students were often under the care of specialists in their hometown area, unless they became ill whilst at university. The practice recognised their role in care coordination, which included keeping all relevant professionals up to date with current treatments.</p> <p>Coeliac review clinics were offered for patients who were diagnosed with coeliac disease. Staff had received training to support these patients. Patients were invited for an annual review of their health. Care and treatment were provided in line with national guidance. Information was provided on the practice website with a link to the Coeliac UK website.</p>

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	58.7%	78.2%	79.3%	Variation (negative)

64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>				
Exception rate (number of exceptions).	24.6% (34)	15.4%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	86.7%	77.4%	78.1%	No statistical variation
Exception rate (number of exceptions).	13.0% (18)	9.9%	9.4%	N/A
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>	81.1%	79.6%	81.3%	No statistical variation
Exception rate (number of exceptions).	11.6% (16)	15.0%	12.7%	N/A

### Any additional evidence or comments

Since the previous inspection, the practice had implemented a new recall system, whereby all appropriate patients aged 17 years and over were invited for review and non-responders repeatedly invited.

Those patients at high-risk of diabetes were also invited to attend for a comprehensive review of their health, which included various relevant blood tests. Information was provided to patients regarding healthy lifestyle and prevention. Patients were also referred to the NHS Diabetes Prevention Programme.

On the day of inspection, it was noted that, compared to the national average, the practice had a significantly higher percentage of diabetic patients who had type 1 diabetes. Generally, type 1 diabetes makes up 5% of all diabetics. However, 89% of the practice's diabetic patients were type 1. Due to the type of diabetes, where alcohol, diet, sleep deprivation and medicine compliance can have a big impact on blood sugar levels, in conjunction with the young student population, this caused difficulties in controlling HbA1c levels for some patients. We were informed by clinicians of how they managed to treat patients appropriately, without causing risk of a hypoglycaemic attack.

The practice informed us of the support and advice they continually gave patients. Some of these patients were also under the care of secondary care services. Monthly clinics were held at the practice by the diabetes specialist nurse from the hospital's young adult diabetes services. Due to the turnover of patients, this also caused some difficulties, as some patients received care elsewhere or did not access care in the UK, despite frequent invites.

The practice undertook reviews of exception reporting and QOF achievements relating to diabetes and could evidence a turnover of patients year on year. It was noted that patients were being exception reported appropriately, in line with the practice policy.

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	68.0%	75.8%	75.9%	Tending towards variation (negative)

assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	2.6% (25)	7.3%	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)	0.0%	90.1%	89.6%	-
Exception rate (number of exceptions).	100.0% (5)	10.1%	11.2%	N/A
<b>Any additional evidence or comments</b>				
<p>The practice invited patients to attend for their asthma reviews, in line with their recall processes. However, we were informed that some patients repeatedly did not attend. It was noted that many of these patients had not been exception reported, as the practice continued to recall these patients. (Exception reporting is the removal of patients from QOF calculations due to several reasons, such as not attending reviews.)</p> <p>We saw a review of COPD patients the practice had undertaken. At the time of our inspection, it was noted they had seven patients in total; six of whom had been inappropriately coded with COPD after a childhood incident of wheezing. (COPD is not a disease experienced in childhood.) They had appropriately exception reported patients who repeatedly declined invitations for review of their care and treatment at the practice.</p>				

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)	83.1%	83.6%	83.0%	No statistical variation
Exception rate (number of exceptions).	14.5% (10)	4.6%	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)	0.0%	92.2%	91.1%	-
Exception rate (number of exceptions).	0.0% (0)	8.6%	5.9%	N/A

## Families, children and young people

**Population group rating:**  
**Good**

### Findings

The services provided by the practice were designed specifically for the needs of young people, as the vast majority of registered patients were aged between 17 and 24 years, who were studying

at educational institutions within Leeds. The practice had a small number of under 16s registered (371), most of whom were dependants of international students.

The practice coordinated care with midwives and health visitors and offered vaccinations as appropriate. The practice explained that some international students and their families arrive in England after receiving their immunisations overseas or having different immunisation schedules to those in the UK. There were also difficulties as students and their families completed educational courses and moved away, without deregistering from the practice. We were informed that approximately a third of the children were internationals.

The practice had a system in place to ensure that all newly registered children were seen by a nurse for a new patient check. Parents were requested to bring immunisation records from their home country at this check. Immunisation details were then updated on the patient's record. Information was forwarded to Child Health at Leeds Community Healthcare to ensure that appropriate future invites for vaccination were sent to patients. Any overdue immunisations were administered by the practice. Children were added to a monthly checklist to ensure they are invited for immunisations in line with the schedule.

The practice had a dedicated template to identify which vaccinations needed to be administered, according to age, on arrival into the country.

There were arrangements in place to identify and review the treatment of newly pregnant women who were prescribed long-term medicines. These patients were provided with advice and post-natal support in according with best-practice guidance.

Patients had access to inhouse contraception services, including long-acting reversible contraception (LARC). Emergency contraception was provided, including insertion of an intrauterine device (IUD) as appropriate, to reduce the risk of unplanned pregnancy. A member of the contraception and sexual health (CASH) team was available at the practice on a daily basis.

The practice worked closely with local specialist services and the Faculty of Sexual and Reproductive Healthcare (FSRH). The sexual health GP lead had been awarded a Fellowship of FSRH in recognition of their work in sexual health.

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)	33	37	89.2%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received	32	41	78.0%	Below 80% uptake

Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)				
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)	33	41	80.5%	Below 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)	34	41	82.9%	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>

### Any additional evidence or comments

The practice website contained a page exclusively relating to childhood immunisations and MMR catch-up. There was information available in a range of languages suitable for their patient population. Additionally, there was a link to the government website which contained guidance for individuals who were uncertain or had incomplete immunisation status.

The practice invitations for immunisation included a code, to enable staff to quickly identify the number of contact attempts that had been made. This was audited and non-responders were acted upon repeatedly. SMS messages were sent to patients, which included a link to the practice website page on immunisations. Again, these were coded to support the practice in monitoring attendance.

The practice had reviewed clinic access to patients, consequently they were in the process of training additional nursing staff in delivering childhood immunisations. They also increased access to appointments to support flexibility for patients.

The practice had been in discussions with the local child health team with regards to notifying them about parents/guardians who did not consent to their child being immunised. As a result, the practice had developed their own "refusal form" which can be saved in the patient's record. Any parents/guardians who declined immunisation for their child were booked an appointment with the safeguarding lead to fully discuss the issues, before the refusal form was signed. A copy of the form was also sent to the child health team.

The practice had developed a range of searches on the computer system, to support them in tracking the number of cancelled or non-attendance for appointments. This allowed them to escalate any concerns to the safeguarding lead and health visitors.

The practice were also working on their "deduction list", as some patients had left the UK. The records of patients who were thought to no longer be in the UK were reviewed by the safeguarding lead following a specific criteria before the patient was removed from the list. We were informed that they also received many "return to sender" letters regarding childhood immunisation letters. Information was available both in the practice and on the website to remind patients to update their contact details.

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

**Population group rating:  
Requires improvement**



## Findings

At the previous inspection, the practice had been rated as requires improvement due to the uptake rates for cervical cancer screening being significantly lower compared to Clinical Commissioning Group (CCG) and national averages. It was noted at this inspection, that the uptake rates had deteriorated further for all cancer screening programmes, such as cervical, breast and bowel, which had resulted in the practice continuing to be rated as requires improvement for this population group.

However, the practice participated in catch-up vaccination programmes, such as those relating to meningitis. Information packs were sent to prospective students about registering with the practice and what services were provided. Drop-in clinics were available for the provision of meningitis and the measles, mumps and rubella vaccinations.

Patients had access to appropriate health assessments, including NHS health checks for patients aged 40 to 74 years. Where any abnormalities or risk factors were identified, patients were followed-up and supported as needed.

Online services were available for patients to access, which included the ability to book or cancel appointments and order prescriptions. A variety of health information and advice was also available via the practice website.

The practice worked with external stakeholders to support this group of patients, such as Student Health Association, Forward Leeds, Gender Outreach Workers, University Police and the Diabetic Transition Team.

The practice were proactive in working with other agencies to improve services for students. The practice had represented general practice on the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) group. Improvements had been made as a result of this work. For example, improved referral pathways into secondary care via the primary care access line, where a dedicated team was available, who were aware of the risks associated with the deteriorating health in this group of patients.

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). (Snapshot date: 01/07/2019 to 30/09/2019) (Public Health England)	22.2%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	43.8%	68.2%	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)	14.3%	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	83.3%	63.8%	68.1%	N/A

occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) (PHE)				
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)	40.0%	51.7%	53.8%	No statistical variation

#### Any additional evidence or comments

There was a dedicated member of staff who undertook appropriate searches on the practice computer system to check eligibility of patients for cervical, breast and bowel cancer screening programmes. The practice had also engaged with the CCG's data quality team to look at their processes and identify any areas where improvements could be made.

Individual patients were contacted to provide them with information and support as necessary. It was acknowledged that many patients were from international backgrounds, who may have required interpreter or translation services. These were provided as necessary. The practice conducted the same processes across the screening programmes for inviting patients and following them up if they did not attend.

We were informed of the difficulties the practice encountered in ensuring telephone/mobile numbers and addresses were up-to-date, as students could change these periodically. The practice had a process in place for following up students, whereby they linked with the university to understand what course a student was on and the length of that course. This supported the practice to identify areas where students may have left the area. If a patient had moved away, the practice was not always notified either by that patient or by registration requests through NHS systems, particularly for international patients. As a result, there was a process in place for reviewing the patient list on a regular basis. If a patient had not been seen for three years, a review of the patient's record was undertaken, contact attempted and a clinical decision made as to whether the patient could be removed from the list.

#### Cervical cancer screening:

The practice identified a number of challenges which impacted on the uptake rates of cervical cancer screening. We were informed that the mobility of students and frequent changes of addresses impacted on the sending and receiving of invites for screening. Some patients were reluctant to attend due to cultural reasons. Many international patients had already attended cervical screening outside of the UK. Some students were included in the numbers of eligible patients, despite only being registered with the practice for a short time. However, the systems in the UK which generated recalls for screening continued to include those patients who had received screening elsewhere. Where possible, information was recorded in the patient's record identifying they had received screening elsewhere. In addition, the year-on-year turnover of patients impacted on the uptake rates. Published data showed there was a fluctuation in uptake rates since 2016; this varied from achieving 90% in 2016 to a gradual below average uptake, which had been steady for the preceding 24 months. Recent data (date range 1.7.19 to 30.9.19) showed that the lowest uptake rates were in the 25 to 49 age range; 1115 (22%) out of 5,061 eligible patients attended screening. The practice had 15 eligible patients in the 50 to 64 age range; 10 of which had attended screening.

From January 2020, the practice had commenced a project to review their cervical screening (smear) non-responders. They had coded all patients who failed repeatedly to respond to invitations and applied the principle of exception reporting to these patients. We saw that they had exception reported 1,220 patients out of an eligible population of 5,119. Out of the remaining 3,899, they had undertaken smears on 1,127 which amounted to an achievement of 29% (this is currently unverified and unpublished data.)



We were informed that although patients would be exception reported, they would continue to send them invitations to attend for screening.

To support improvement in uptake rates, the practice had taken a number of steps. For example, they organised a “pink week” campaign once a term to highlight the importance of cervical screening. During this time, appointments were made available. Information was available on the practice website and screening was offered to eligible patients at the time of registration and new patient check. The practice also had a system in place to ensure that all eligible transgender patients were invited for screening.

If English was not the first spoken language of the patient, they provided information in other appropriate languages, such as Mandarin, Arabic, Bengal, Tamil and Urdu. Letters and text messages were sent to patients advising them of the benefits of attending for their screening. They had also developed a clear process which they conducted on a weekly basis to deal to manage cervical screening. This included sending patients links to a video which provided information.

We saw that the practice had increased the numbers of appointments available for cervical screening and were flexible in line with patients’ availability.

**Breast cancer screening:**

At the time of our inspection, there were 16 patients eligible for breast cancer screening (10 of whom were internationals). Contact was made with each eligible patient, to give them appropriate information and advice. It was recorded in the patient’s record when contact had been made. The practice also sent text message reminders.

**Bowel cancer screening:**

At the time of our inspecton the practice had six (four of whom were internationals) patients within the eligible age range of 60 to 69 years. We were informed that patients were encouraged to attend the screening. However, due to the small number of eligible patients, any who chose not to participate had a significant impact on uptake rates.

Contact was made with each eligible patient, to give them appropriate information and advice. It was recorded in the patient’s record when contact had been made. The practice also sent text message reminders.

**Cancer review within six months of diagnosis:**

At this inspection, data showed the practice had made significant improvements in this area; they had achieved 83.5% reviews, compared to 12.5% previously. We were informed that some of the low rate had been attributed to coding issues. They had new influxes of patients in September and had reviewed these to support appropriate care and treatment. However, we were informed that some of the patients returned home for their care.

**People whose circumstances make them vulnerable**

**Population group rating: Good**

**Findings**

The practice had a good understanding of this patient group and recognised that many patients may have moved away from their support network, be socially isolated, financially vulnerable or unsure of how to access support.

The practice had seen an increase in the number of transgender patients and had implemented processes to ensure they were offered the opportunity to access appropriate support, treatment and screening. For example, the practice hosted Gender Outreach Worker appointments. Staff had received training to support improvements in communication, interaction and understanding regarding this group of patients.

The practice worked closely with colleagues in local academic institutions to increase awareness of what support was available for vulnerable patients.

The practice worked in partnership with Forward Leeds and the local community police officers to increase awareness of risk reduction programmes, such as alcohol and recreational drug awareness and risks of sexual violence.

The number of patients who had a learning disability was extremely low. However, the practice informed us they supported these patients in line with their individual needs.

At the time of our inspection, there were no patients on end of life care. We were informed, again, that patients identified as being end of life generally returned to their family to be cared for and supported.

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

**Population group rating: Good**

### **Findings**

At the previous inspection, this population group had been rated as being requires improvement due to the performance for some mental health indicators being significantly lower, compared to CCG and national averages. It was noted at this inspection, that those indicators had significantly improved and were now above CCG and national averages.

Patients were offered a face-to-face consultation with a GP, however, telephone consultations were available as needed.

The practice worked in partnership with a local organisation to offer patients an appointment with a mental health worker. This service provided early interventions for patients who had mental health issues and aimed to improve patient outcomes without duplicating services already available.

The practice worked closely with Yorkshire Centre for Eating Disorders, university counselling and support services and community mental health services. As a result of this work, the practice was involved in the First Episode and Rapid Early Intervention (FREED) pilot. This service is designed to give young people rapid access to specialised evidence-based treatment and support tailored to their needs.

The practice had contributed to a networking event with local mental health services to discuss gaps in service provision and were committed to developing services further.

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 good working relationships with the local mental health and crisis teams, where they could refer patients.

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>	92.7%	90.4%	89.4%	No statistical variation
Exception rate (number of exceptions).	34.9% (22)	10.6%	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>	93.9%	90.6%	90.2%	No statistical variation
Exception rate (number of exceptions).	22.2% (14)	9.1%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	0.0%	84.8%	83.6%	-
Exception rate (number of exceptions).	0.0% (0)	6.3%	6.7%	N/A

#### Any additional evidence or comments

The practice had reviewed their processes for recording annual health checks. They had worked with the CCG IT team to develop appropriate templates to record the required information. Published data showed the practice had improved significantly in the QOF mental health indicators. For example, the percentage of patients who had a documented care plan in place had risen from 6.5% to 92.7%; the number of patients with a recorded alcohol consumption had risen from 48.5% to 93.9%. The practice had reviewed the records of those patients they had exception reported. We were informed, again, that some patients may have moved away. It was noted that patients had been appropriately exception reported, in line with the practice policy.

#### 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)	362.5	539.6	539.2
Overall QOF score (as a percentage of maximum)	73.4%	96.7%	96.7%
Overall QOF exception reporting (all domains)	5.0%	5.9%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes

The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Yes
Quality improvement activity was targeted at the areas where there were concerns.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

We saw an audit that had been undertaken relating to coeliac disease, looking at how the practice was responding in line with national guidance and offering patients an annual review of their health. We saw that changes had been recommended, such as ensuring the correct immunisations were offered and adding additional information to the template, particularly relating to diet. The practice had set up a recall programme to review patients using the reviewed template and intended to repeat the audit 12 months after the initial audit.

### Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: There was a comprehensive induction programme for new staff, which included shadowing other staff members. Salaried GPs had an inhouse appraisal, in addition to the external GP revalidation process. We saw that all staff had received Disclosure and Barring Service (DBS) checks.	

There was a matrix in place where DBS, General Medical Council (GMC), Nursing and Midwifery Council (NMC) checks, appraisal and training were recorded.

## 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.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes

## Helping patients to live healthier lives

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

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

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	87.6%	95.4%	95.0%	Variation (negative)

smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	0.4% (4)	0.8%	0.8%	N/A

## Consent to care and treatment

**The practice was able to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.**

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes
Explanation of any answers and additional evidence: Staff had received training in the Mental Capacity Act (MCA). They had a good understanding of the Gillick competency test. This test is used to determine if a child under the age of 16 years has sufficient understanding and the competence to make a decision regarding their care and treatment.	

### 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.