Care Quality Commission

Inspection Evidence Table

Woodlea House Surgery (1-550826076)

Inspection date: 29.01.2020

Date of data download: 06 January 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.	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: Clear advice was documented by all clinical staff, to ensure patient safety in line with national guidelines. Practice policy was that all patients attending with symptoms which could indicate serious illness were	

always seen on the day, appointment slots were reserved in the event of emergencies or made available in the event a patient required urgent treatment that day. Additional appointments were available at the nearby Urgent Treatment Centre if demand was high. On the day of our inspection we checked the practices appointment system and found that both urgent and routine appointments were available at suitable levels for this small practice.

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)	1.11	0.70	0.74	No statistical variation

Older people — Population group rating: Good

Findings

- Woodlea House Surgery is part of the south coast medical group's frailty team (FACT).
- There was a named person for staff to contact if there concerns about an older person becoming more vulnerable. If a concern was raised this triggered a FACT visit.
- A pharmacist was systematically providing medication reviews for this cohort and arranging any book tests/ reviews, they could book patients in for medication reviews.
- The practice used a nationally recognised frailty tool to identify those most at risk and provide support.
- A GP carried out a weekly round at a local residential care home.
- GPs visited all housebound patients at home in November and December to administer the influenza vaccine and to carry out face to face medication reviews.
- The recall team contacted relevant patients to offer influenza, shingles and pneumonia vaccinations.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- We have rated this population as requires improvement due to the higher than average levels of exception reporting in the quality outcomes framework (QOF) for patients with long term conditions. The practice provided unverified data to evidence improvements.
- There were however, also positives for treatment and care of this population group;
- Patients with diabetes were offered a six-monthly review of their health and care to ensure their needs were being met. Newly diagnosed diabetics, or those identified as pre-diabetic were referred to a structured education program. Refresher courses were available for those who required additional support.
- Patients with diabetes had access to further specialist support including a diabetic dietician and psychologist for support with healthy living and needle phobias. This helped patients to monitor healthy eating, independent care and tackle specific concerns or fears they had about their condition. Clinicians responsible for treating patients with long term conditions were competent to do so and had attended relevant training courses.
- Patients using inhalers more frequently than prescribed for were invited in for a review and if indicated, lung function was assessed with spirometry in line with best practice.
- Patients with acute COPD were offered pulmonary rehabilitation. Patients with COPD were offered rescue packs.
- Patients with COPD who had an acute admission were followed up by the practice team on discharge and also had community matron input if required, this was discussed at monthly multi-disciplinary (MDT) meetings
- There was proactive case finding for all chronic diseases. For example, diabetic screening for those with poor healing of wounds, and atrial fibrillation screening for over 65's when having the influenza vaccination
- The practice offered 24-hour blood pressure monitoring and the use of home blood pressure monitors
- Patients with long term conditions were offered personalised management plans
- The practice could refer patients, with their consent, to local social prescribers and life coaches to help with the management of their long-term conditions.

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)	84.4%	82.5%	79.3%	No statistical variation

Exception rate (number of exceptions).	40.7% (88)	18.6%	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)	82.1%	79.0%	78.1%	No statistical variation
Exception rate (number of exceptions).	22.2% (48)	13.1%	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)	77.4%	82.8%	81.3%	No statistical variation
Exception rate (number of exceptions).	32.4% (70)	16.6%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) (QOF)	71.8%	77.2%	75.9%	No statistical variation
Exception rate (number of exceptions).	25.0% (72)	12.0%	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)	90.9%	90.5%	89.6%	No statistical variation
Exception rate (number of exceptions).	30.0% (33)	15.3%	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)	80.5%	83.6%	83.0%	No statistical variation
Exception rate (number of exceptions).	23.6% (135)	5.7%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)	84.2%	90.9%	91.1%	No statistical variation
Exception rate (number of exceptions).	3.4% (2)	6.6%	5.9%	N/A

Any additional evidence or comments

The practice recognised that their exception reporting for monitoring of long-term conditions was higher than both the local and national averages. The practice had obtained support for this from the south coast medical group. The practice was in the process of merging with this group and had received support prior to the final merger date of 1 April 2020. This had enabled the high exception reporting to be addressed.

Some of the indicators in the table above have been retired from the scheme since March 2019 and were therefore not measured in the current financial year. Exception reporting data to make direct comparisons with the data above will not be available until after 31 March 2020. However, it was clear that the practice had exception reported minimal patients and a high number of patients had already had reviews, with nearly two months left of the current financial year for this to increase further. Unverified data supplied by the practice on the day of inspection 29 Jan 2020 from the computer-based “How am I driving” system, showed that;

Of the 197 patients with diabetes on the register, 132 had received health reviews since 1 April 2019, 2 had been exception reported. There were 63 patients remaining to review by 31 March 2020.

Of the 108 patients with COPD on the register, 86 had received health reviews since 1 April 2019, 4 had been exception reported. There were 18 patients remaining to review by 31 March 2020.

Of the 264 patients with asthma on the register, 209 had received health reviews since 1 April 2019, 1 had been exception reported. There were 54 patients remaining to review by 31 March 2020.

Of the 71 patients with atrial fibrillation on the register, 61 had received health reviews since 1 April 2019, 9 had been exception reported. There was 1 patient remaining to review by 31 March 2020.

The practice told us they had made improvements by doing the following:

The practiced had identified a dedicated member of staff (the recall team manager) to oversee the process for patient recalls in order to reduce their exception reporting levels.

The practice had changed the system for exception reporting. Prior to March 2019 the practice had a

process of exception reporting patients after two unsuccessful invitations to their long-term condition review. Post April 2019 the practice had ensured staff contacted the patient on a third occasion to encourage attendance, and there was now clinical oversight before any patient was exception reported. Members of staff now proactively invited these patients in for review. Patients were also opportunistically booked in for their reviews when they attended for other reasons.

Woodlea House Surgery had received support from the practice they were merging with around reviewing exception reporting levels and a plan was in place to continue the emphasis upon this post-merger after 1 April 2020.

Families, children and young people Population group rating: Good

Findings

- A monthly search was carried out to identify any overdue immunisations, parents/guardians were contacted by the reception team to book in, if they were unsure whether they wanted the child to have immunisations they could be referred to the health visitor or have an appointment with a practice nurse to discuss their concerns.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and liaised with health visitors when necessary.
- It was practice policy that at post-natal check-ups the new parents were asked about low mood and followed up if there were any concerns. Contraception was also discussed.
- 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 seen first by the GP then referred to the midwife, the pertussis vaccine was offered from 18 weeks gestation.
- Young people could access confidential advice 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)	25	26	96.2%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)	25	28	89.3%	Below 90% minimum

(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)	25	28	89.3%	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)	25	28	89.3%	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

- Whilst between April 2018 March 2019 the practice had not met the minimum 90% target for three of the four childhood immunisation uptake indicators, the figure achieved was 89% The WHO target is 90%, 25 out of 28 children had been vaccinated. Only three children had not been recorded as having received their vaccinations. The practice had contacted the parent/guardians of the three on more than three occasions.
- The practice provided unverified data from January 2020 to evidence that they were currently meeting the WHO target of 90% and that 30 out of 31 children (97%) had received their immunisations for each of the three previously amber indicators in the table above between April 2019 to January 2020 (and 100% in the green indicator in the table above).

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

Findings

- The practice acknowledged their current cervical cancer screening achievement, and was working on this.
- The practice had identified 16 patients with new cancer diagnosis. Of these, 15 had received a full review within six months of their diagnosis.
- 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.
- Extended hours ran at the weekend, so patients can access care and appointments when not working.
- The practice actively identified military veterans and had an armed forces covenant policy in order to ensure veterans received priority access to secondary care for any conditions relating to service to their country.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	68.4%*	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	72.0%	75.9%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	51.7%	62.4%	57.3%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	50.0%**	62.6%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	59.4%	51.6%	51.9%	No statistical variation

Any additional evidence or comments
*The practice had carried out a targeted campaign to achieve improvement in cervical screening figures and had achieved 74% between April 2019 to January 2020. This was above the 70% uptake target, with a continued campaign plan to reach 80% in the remaining two months until the end of March 2020. The practice had utilised national campaigns to increase attendance, and for a dedicated week the practice put up a cervical screening information board to encourage attendance. There was a high rate of patients who did not attend for their smears, and the patient was always telephoned and offered another appointment. Opportunistic screening was done when time allowed, or a discussion held if the patient coincidently attended for a different review to encourage them to come back for their screening. For patients who were nervous, the practice offered an appointment with two nurses present for reassurance. **The practice had successfully completed 100% of their cancer care reviews this year. There were 137 patients in this group at this small practice. They had achieved this by targeting these patients for review.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required
- The practice had accessed support from the paramedics employed by the south coast medical group (in advance of their impending merger), this had been invaluable for vulnerable patients at home, instead of waiting until after surgery to be triaged and visited they were spoken to or seen much earlier in the day.
- All patients with a learning disability were offered an annual health check. So far 13 out of 24 had been completed with further checks booked in.
- End of life care and vulnerable patients were discussed at the monthly multi-disciplinary team (MDT) meetings, minutes shared and discussed with staff not able to attend.
- GPs met with other GPs and clinicians after morning and afternoon surgeries to discuss any concerns or learning points.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice had a system to identify people who misused substances, in order to provide appropriate support.

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' were offered in house.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Woodlea House Surgery was a dementia friendly practice, with appropriate signage.
- Patients with poor mental health, including dementia, were referred to appropriate services
- Signposting to relevant support services was used and encouraged, patients could access a local support centre in Bournemouth which opened every day from 4.30pm to midnight for those who were struggling with their mental health. Patients could also access a 24-hour helpline or use the 'Every Mind Matters' website to create their own personal mental health care plan.

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%	92.6%	89.4%	No statistical variation
Exception rate (number of exceptions).	4.8% (2)	16.3%	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)	95.1%	89.6%	90.2%	No statistical variation
Exception rate (number of exceptions).	2.4% (1)	14.7%	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)	89.5%	85.1%	83.6%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	6.8%	6.7%	N/A

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)	559	545	539.2
Overall QOF score (as a percentage of maximum)	100%	97%	96.4%
Overall QOF exception reporting (all domains)	13.1%	12%	10%

	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

There were examples of clinical audits and other improvement activity in the last two years. We saw two full cycle clinical audits which had been completed by the GPs and the pharmacist. For example, on medicines safety and on asthma inhaler usage which had resulted in improvements to patient care by reducing dosages or moving to lower risk medicines.

There was evidence of historic clinical audit activity. Between 2014 to 2016 there had been nine clinical audits completed, four of these were complete cycle audits. The practice told us that difficulties in recruiting GPs had made it challenging to complete a full set of clinical audits. There was a plan to address this following the merger on 1 April 2020. The leadership team of south coast medical group told us that complete cycle clinical audits were a feature of their work, and that shared learning took place between practices belonging to the group.

Post inspection the provider informed us that they had undertaken several other audits around areas such as prescribing, health and safety and staff immunisation. We were unable to corroborate this as relevant documents were not provided.

Any additional evidence or comments
Significant events were discussed with all staff at time of event, the practice held an annual review of complaints and significant events. Shared learning took place.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	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	Y

their performance was poor or variable.	

Explanation of any answers and additional evidence:

Practice staff had protected learning time, Dorset clinical commissioning group (CCG) arranged and funded cover for this time.

Staff used e-learning for health program for learning, clinical staff had one week's pro-rata study leave and non-clinical staff can attend training appropriate to their role.

New staff had three sessions of induction with handouts provided and opportunities to discuss any learning needs.

GPs and nurses had appraisals as part of their revalidation.

Nurses had completed the relevant training to ensure they have the correct competencies, support could also be sought from the team at the south coast medical group.

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

The team meet monthly for a multi-disciplinary team meeting (MDT) meeting, vulnerable patients and palliative care patients were discussed. There was an MDT co-ordinator who organised these meetings and minuted them. Evidence showed that these meetings had been helpful in delivering care to some of the most vulnerable patients.

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	Y

developing a long-term condition and carers.	
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:

The practice proactively signposted patients and carers to relevant services as well as offering them support. Patients nearing the end of life stage were treated as individuals, each patient had different requirements and expectations and the practice prepared individualised plans for each, with help from the district nursing and palliative care teams.

Clinicians encouraged patient self-care with the use of care plans and goal setting at reviews. Since using Arden's templates which provided prompts, staff told us it had been easier to give patients up to date literature to help them with this process.

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)	96.5%	94.9%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.6% (6)	1.3%	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: Arden's templates on the computer system were used which prompted consent recording.	

Well-led Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: Woodlea House Surgery will be joining the south coast medical group from 1 April 2020, this decision was taken in consultation with patients, to ensure sustainability for the practice. The process has been undertaken with support from the patient participation group (PPG) and Dorset clinical commissioning group (CCG) and the practice had been working closely with the south coast medical Group to ensure that this was a positive experience for patients. Staff provided us with very positive feedback about the visibility of the leadership team at the practice and from south coast medical group, who had been extremely supportive.	

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 vision to become part of the south coast medical group was imminent. The practice was confident that the outcome would be positive.

We met with the leadership team of south coast medical group at the practice on the day of inspection. The group had a clear set of values and a vision. The new set of visions and values were already on display around the practice. We spoke with all members of staff at this small practice. This included the practice nurse, two GPs, two receptionists, a pharmacist and three management and administration staff. Staff were able to identify the future plans of the practice and the vision and values.

There was signage in the waiting room about the impending merger. We spoke with four patients on inspection day. Three of whom were aware of the impending merger. All patients provided us with positive feedback about the practice.

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:

Practice leaders were committed to being open and encouraged a no blame approach. The practice had a system for managing complaints, seeking to learn from them and feedback any outcomes to the

person(s) who had raised any issues.
The practice had a Freedom to Speak Up Guardian and a whistle blower policy.

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

Source	Feedback
Staff interviews	We spoke with all available staff at the practice. This included GPs, the practice nurse, pharmacist, a QOF manager, the practice manager, administration and reception staff. All staff we spoke with were very positive about working at the practice and felt supported in their roles. Staff had been consulted about the impending merger and were positive about their future roles.

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 was in the process of merging with south coast medical group, which offered them clear governance and management systems. For example, a full range of up to date policies on all aspects of primary care and its governance available on shared computer systems. Other benefits to good governance and management included a vision, values, roles and structures with named individuals available to support staff in numerous areas. Staff we spoke with at the practice felt very supported in their roles.

The practice acknowledged the issues with exception reporting and had an improvement plan underway in partnership with south coast medical group to address it. The leadership team at south coast medical group were working with the practice to ensure reviews of governance systems and processes were undertaken to make improvements to patient's quality of care. Improvement work continued on this. The merger was due to be completed on 1 April 2020 following which the practice planned to continue the improvements to ensure they became fully embedded.

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 detailed assurance framework that brought together systems, procedures and processes to manage patient safety risks. This included regular meetings with managers and staff, significant event and complaints monitoring and clear staff structures and accountabilities.

Regular meetings were held with safeguarding being a standing agenda item to ensure that specific patients were made aware to all relevant staff.

The practice's safeguarding policies identified the correct levels of training required for practice staff in line with national guidance.

On the day of our inspection we found that a counsellor who provided life coaching from a room at the practice had not received safeguarding training. The practice had a plan in place to address this. Shortly after our inspection the practice provided evidence that the life coach counsellor had completed their safeguarding training.

Practice oversight of recruitment processes was embedded. Five staff files we looked at showed that appropriate checks had been carried out prior to recruitment, annual appraisals had taken place and training had been recorded. Where there were training gaps, the practice had a plan in place to address these.

Appropriate and accurate information

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

	Y/N/Partial

Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: Evidence from the previous quality outcomes framework QOF year showed high exception reporting which the practice had acted upon and made improvements in relevant areas.	

If the practice offered online services:

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: We received 25 CQC comment cards from patients at the practice. Twenty-four of these were very positive, describing helpful, friendly and professional reception staff, nurses and GPs. Patients were supportive of the impending move to merge. One comment card described a long wait for an appointment. Written evidence showed that the PPG had been supportive and helpful with plans to become part of the south coast medical group. The PPG had developed the wording of a letter sent to all patients informing them of the planned merger. This had been done in order to obtain perspective on what the patient would want to see in such a letter. The practice had adopted the PPG input and the letter had received a positive response.	

Feedback from Patient Participation Group.

Feedback
The practice had an active Patient Participation Group (PPG). CQC Inspectors spoke with four patients during the inspection, who provided us with positive feedback about the practice. There was a web page on the practice website dedicated to the PPG. This web page showed that regular patient surveys took place. The vast majority of feedback was extremely positive and showed that patients were very satisfied with the service.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: All staff were encouraged to learn and improve and ask questions if they were not sure about something, clinical staff supported each other during clinic time and debriefed afterwards to share any learning points. Learning from external study days was shared. Staff were given time to attend off-site training events or to complete online training. If this was completed at home, they were paid for this. Learning needs were discussed at annual appraisal. The practice had formulated a plan to meet future challenges and was successfully merging into south coast medical group on 1 April 2020, in order to ensure continued services for patients.	

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