

# Care Quality Commission

## Inspection Evidence Table

### Langley House Surgery (1-569179442)

Inspection date: 21 February 2020

Date of data download: 17 February 2020

## Overall rating: Good

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

## Safe

## Rating: Good

### Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies 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

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

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: 01/10/2019	Y
There was a record of equipment calibration. Date of last calibration: 1/10/2019	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: December 2019 - Langley	Y
There was a log of fire drills. Date of last drill: 21/10/2019	Y
There was a record of fire alarm checks. Date of last check: 18/02/2020	Y
There was a record of fire training for staff. Date of last training: 21/01/2020	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: Langley House - 27/03/2019 Bosham branch – 26/11/2019	Y
Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence:	
<p>The main practice premises at Langley House had been visited by West Sussex Fire and Rescue Service in January 2019 for a fire safety evaluation. They advised that the practice showed adequate fire safety but that improvements could be made. Suggestions for improvement were listed in a letter to the practice. We saw that the practice had acted on all the suggestions which included the undertaking of a suitable and sufficient fire risk assessment to identify the safety measures the practice had in place and any further measures it may need to take. This was because the practice's existing fire risk assessment was not considered suitable and sufficient and without this fire safety arrangements could fall to an unacceptable level.</p> <p>We saw that the practice had acted on all the suggestions for improvement and had commissioned an external provider to undertake a thorough fire risk assessment. This was undertaken in March 2019. The</p>	

fire risk assessment identified significant findings which were rated for risk and the action required.. We saw from the action plan that the practice had implemented the additional control measures to mitigate all the risks that had been identified, with the exception of the medium rated risks as some were still outstanding. The time frame for the implementation of all the control measures ranged from immediate to six months. Some risks identified as medium, the practice had been unable to implement. For example, replacing glazing above doorways, the installation of fire doors and compartmentation and automatic detection systems. They told us that this was because of the high cost, restrictions due to the listed building status and the fact that they were awaiting the outcome of an improvement bid to the clinical commissioning group to help fund more suitable premises. This meant that the practice was unable to assure that the premises were safe to use for their intended purpose and were used in a safe way.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: January 2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: January 2020	Y

### Infection prevention and control

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

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: August 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: We saw that the practice had acted on issues identified in the last infection prevention and control audit. For example, the organising of hand hygiene training for staff and regular hand hygiene audits.	

## Risks to patients

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

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

## Information to deliver safe care and treatment

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

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

## Appropriate and safe use of medicines

### The practice systems for the appropriate and safe use of medicines were effective, 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)	0.80	0.86	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)	12.3%	10.6%	8.5%	Tending towards variation (negative)
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)	6.97	5.73	5.60	Variation (negative)
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)	1.88	2.06	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

Medicines management	Y/N/Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
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
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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had risk assessed the need for and held appropriate emergency medicines. Systems were in place to monitor expiry dates. However, at the branch surgery we found two medicines were past their expiry date. We were reassured that this would be resolved quickly.</p>	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	N/A
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Partial
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Partial
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>Explanation of any answers and other comments on dispensary services:</p> <p>An agreed stock of medicines including antibiotics and pain relief were kept at the branch surgery for the GPs to dispense to patients who would find it difficult to access the main surgery or a community pharmacy in a timely manner. However, the practice was not able to demonstrate how these medicines would be suitably labelled. They were not able to demonstrate that the patient received the required information to take these medicines as prescribed and store them safely.</p> <p>The practice offered a delivery service that had been risk assessed. However, the practice was unable to provide assurance that they were following professional body advice, for example that the delivery drivers should have had a current check with the Disclosure and Barring Service. The drivers were self-employed and whilst they had signed a document to say they had a clear DBS check, the practice had not asked to see evidence confirming this.</p>	

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

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

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

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

Event	Specific action taken
A pathology result that required action was sent by a receptionist to the duty GP, who then sent a message back to the receptionist asking them to send the result to the patient's own GP. However, the receptionist concerned had gone off shift and did not see the message until the following day. The patient was contacted but the timeliness could have been improved.	We saw evidence that GPs were reminded to respond to staff groups rather than individuals if urgent action was required. Each individual staff member was reminded to check their individual tasks before they leave their shift to double-check that urgent matters had been dealt with.

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

## Effective

## Rating: Good

### Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment were 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

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	1.01	0.71	0.74	No statistical variation

## Older people

## Population group rating: Good

### Findings

- The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. The practice worked with a multi-disciplinary team to develop anticipatory care plans that aimed to prevent unnecessary admission to hospital.
- Patients diagnosed with terminal illness were identified and a register of these patients was maintained. The practice met regularly with the palliative care team to ensure the care needs of these patients were being met.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## People with long-term conditions

Population group rating: **Good**

Findings	
<ul style="list-style-type: none"> <li>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.</li> <li>Staff who were responsible for reviews of patients with long-term conditions had received specific training.</li> </ul>	

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	84.4%	85.7%	79.3%	No statistical variation
Exception rate (number of exceptions).	11.0% (69)	18.5%	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>	75.5%	79.8%	78.1%	No statistical variation
Exception rate (number of exceptions).	15.2% (95)	15.4%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	86.1%	82.5%	81.3%	No statistical variation
Exception rate (number of exceptions).	18.5% (116)	21.4%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	83.9%	77.0%	75.9%	Tending towards variation (positive)
Exception rate (number of exceptions).	15.9% (99)	15.8%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	94.7%	92.0%	89.6%	No statistical variation
Exception rate (number of exceptions).	17.4% (28)	16.7%	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) <small>(QOF)</small>	73.7%	82.1%	83.0%	Variation (negative)
Exception rate (number of exceptions).	4.0% (67)	6.5%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) <small>(QOF)</small>	84.8%	89.5%	91.1%	No statistical variation
Exception rate (number of exceptions).	2.0% (6)	6.7%	5.9%	N/A

#### Any additional evidence or comments

The practice was aware of lower than average performance for patients with hypertension and had put measures in place to address this. We saw up to date figures provided by the practice (unverified by the CQC) which showed improved performance for the current year.

### Families, children and young people

### Population group rating: Good

#### Findings

- The practice had met the minimum 90% target for four of four childhood immunisation uptake indicators. Non-attenders for immunisations were pro-actively followed up.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	95	98	96.9%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	97	105	92.4%	Met 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)	97	105	92.4%	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)	98	105	93.3%	Met 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's uptake for cervical screening was 70%, which was below the 80% coverage target for the national screening programme. Clinicians told us they opportunistically encouraged uptake if they were seeing the patient for something else and patients who did not attend for cervical screening appointments were telephoned to encourage them to re-book. The practice was also in the process of training an additional practice nurse so that they could undertake cervical screening. This meant more women would be screened. Patients could also attend for cervical screening at weekends at one of the GP access hubs.
- 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). (01/07/2019 to 30/09/2019) (Public Health England)	70.2%	N/A	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)	68.7%	71.9%	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)	61.6%	61.1%	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)	48.8%	68.1%	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)	51.2%	52.5%	53.8%	No statistical variation

### People whose circumstances make them vulnerable

Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>• Same day appointments and longer appointments were offered when required.</li> <li>• All patients with a learning disability were offered an annual health check.</li> <li>• End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.</li> <li>• The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.</li> <li>• The practice demonstrated that they had a system to identify people who misused substances.</li> </ul>

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

Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>• 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.</li> <li>• Same day and longer appointments were offered when required.</li> <li>• 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.</li> <li>• Patients with poor mental health, including dementia, were referred to appropriate services.</li> </ul>

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)	95.3%	91.8%	89.4%	No statistical variation
Exception rate (number of exceptions).	22.0% (18)	24.2%	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)	89.2%	92.6%	90.2%	No statistical variation
Exception rate (number of exceptions).	20.7% (17)	18.7%	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)	89.6%	87.1%	83.6%	No statistical variation
Exception rate (number of exceptions).	7.6% (11)	8.3%	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)	540.1	550.2	539.2
Overall QOF score (as a percentage of maximum)	96.6%	98.4%	96.7%
Overall QOF exception reporting (all domains)	5.1%	7.5%	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

Any additional evidence or comments
The practice had undertaken several audits in the past two years. For example, an audit of the prescribing of a high-risk medicine resulted in improved identification of patients taking the medicine and safer more effective prescribing. It had also taken part in an audit of end of life care and was taking the lead on implementing the results across the primary care network.

## 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.	Partial
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:	
The practice had recently recruited a qualified nurse who had not had prior experience of general practice. The practice told us that the nurse was being trained, observed and assessed in key competency areas in order to identify further training needs. However, there were no records of the competency assessments in order to demonstrate that that this was the case.	
The practice actively encouraged staff to develop additional skills and progress their careers. For example, two receptionists had undertaken additional training to become health care assistants.	

## Coordinating care and treatment

Staff worked 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

## Helping patients to live healthier lives

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

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

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	90.8%	94.0%	95.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	1.3% (36)	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

## Well-led

**Rating: Good**

### Leadership capacity and capability

**Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.**

	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
<p>Explanation of any answers and additional evidence:</p> <p>It was clear throughout the inspection that practice leaders understood the challenges to quality and sustainability. These included a rapidly increasing patient list size due to local housing developments and lack of space in the current listed building premises. The practice had been in discussions with the clinical commissioning group for several years and more recently with the district council and had commissioned a feasibility study for alternative solutions.</p> <p>Practice leaders had also faced challenge of management succession planning through the retirement of three longstanding GPs over the past few years. They had planned ahead and recruited successfully which meant they were well placed for the future.</p> <p>Two of the GPs were undertaking a management development programme designed to facilitate and encourage leadership skills and strengthen local workforce resilience.</p> <p>The practice had engaged with its local primary care network (PCN) and was actively involved in the sharing of good practice. It was the lead practice in the PCN for the implementation of improved quality in end of life care for patients.</p> <p>Staff we spoke with told us that leaders were visible and approachable and there was an 'open door policy'. They felt they could raise concerns at any time, and these would be addressed.</p>	

### 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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a clear ethos which they summarized as 'Striving for Excellence'. There was a clear practice development plan in place, which detailed key objectives and outcomes. These were regularly monitored.</p>	

## Culture

### The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y

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

Source	Feedback
Staff interviews	<p>Staff we spoke with told us that they loved working at the practice. They told us that they felt well supported by their managers who they described as available, approachable, encouraging and understand of their needs. They told us that they felt they had access to all the training and development they needed to for their roles. They gave an example of recent training on how to deal with difficult patients and told us how useful they had found it. They said they felt valued and that practice leaders often thanked them for their work.</p> <p>Staff also said that they felt listened to and that their ideas were listened to and taken on board if appropriate. They had regular meetings where the agenda was set by the staff to allow them to drive the meeting and raise issues and concerns. Staff told us they felt that communication throughout the practice was good</p> <p>Staff enjoyed regular social events which included practice walks ending in lunch, afternoon country house tea, skittles and a corporate challenge run.</p>

## 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

### 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.	Partial
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:	
Whilst the practice had ensured that all fire risks had been suitably identified, not all the additional control measures required had been implemented.	

### 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

### 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 a virtual patient participation group whose views and opinions were sought by email. We saw evidence to show that the practice sought and acted on their views. For example, it had sought their views on its home visits policy and made changes in response.

The practice also utilised feedback from the Friends and Family Test and NHS Choices. It had also undertaken its own patient survey.

Staff told us their views were listened to and acted on in the planning of services. For example, an increase in health care assistant appointments so that practice nurse time could be utilised more effectively.

Feedback from Patient Participation Group.

#### Feedback

The practice had a virtual patient participation group whose views and opinions were sought by email. We spoke with representatives from the group who told us that the practice had sought their views. For example, on the home visit policy, the appointment system and prescriptions. They told us that they felt that the practice was responsive to patient views. Some felt that an actual group would enhance patient engagement. They also thought it would be useful for the practice to hold more patient education events, for example on how to book appointments on line and specific health topics.

Feedback from CQC Comments Cards.

#### Feedback

We received 52 comments cards from patients. Comments about the practice and its staff were overwhelmingly positive. Patients described the service they received as 'first class', 'exemplary and 'brilliant'. They commented that they could usually get an appointment when they needed to, and that the appointment system worked well. They described all staff as helpful, caring and professional.

### 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:	
<p>The practice was involved in various improvement example, it had taken the lead on a project aimed at improving end of life care for patients across initiatives. For the primary care network (PCN). Learning was shared effectively and widely, for example with significant event analysis at PCN level.</p> <p>The practice had a comprehensive programme of clinical audit which had led to improved patient outcomes in relation to prescribing and referrals to secondary care.</p>	

## 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 considered 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 considering the types of people who will be receiving that treatment.