

Care Quality Commission

Inspection Evidence Table

Dinas Lane Medical Centre (1-549971167)

Inspection date: 19 Feb 2020

Date of data download: 30 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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The training matrix indicated all staff had completed the following relevant courses: <ul style="list-style-type: none">• Equality and diversity;	

- Active sign-posting;
- Care navigation training provided by Knowsley Clinical Commissioning Group
- Data protection
- Staff indicated they felt well prepared for dealing with online and digital services.

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>	1.69	1.10	0.74	Variation (negative)

Any additional evidence or comments

The practice employed a qualified clinical pharmacist who was working alongside the CCG medicines optimisation pharmacist to decrease hypnotic medicines and antimicrobial prescribing. The practice was aware that hypnotic prescribing data indicated there was a higher use of hypnotic medicines than the local and national averages. Audits have been completed and action taken included implementation of the pan-Mersey prescribing guidelines. Audits and reports indicated clear processes were in place in place to manage and monitor how high- risk medicines were prescribed

Older people

Population group rating: GOOD

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age. An electronic frailty index was completed as required.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care, records indicated that assessments were detailed and completed to a high standard.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered high intensity statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring and referred to a local service.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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>	71.2%	73.7%	79.3%	No statistical variation
Exception rate (number of exceptions).	3.1% (21)	9.0%	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>	76.0%	78.5%	78.1%	No statistical variation
Exception rate (number of exceptions).	2.3% (16)	5.1%	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) <small>(QOF)</small>	78.1%	78.8%	81.3%	No statistical variation
Exception rate (number of exceptions).	7.3% (50)	7.5%	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>	74.6%	73.0%	75.9%	No statistical variation
Exception rate (number of exceptions).	5.0% (32)	5.0%	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) <small>(QOF)</small>	92.2%	84.6%	89.6%	No statistical variation
Exception rate (number of exceptions).	7.8% (26)	5.5%	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	82.5%	84.4%	83.0%	No statistical variation

measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>				
Exception rate (number of exceptions).	1.9% (30)	3.1%	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>	92.0%	94.4%	91.1%	No statistical variation
Exception rate (number of exceptions).	4.9% (9)	5.9%	5.9%	N/A

Families, children and young people

Population group rating: **Good**

Findings

- The practice had met the minimum 90% target for one of four childhood immunisation uptake indicators. The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for three of four childhood immunisation uptake indicators. . The practice indicated they had achieved the target of 95% by giving patients open appointments based the week-ending of the due date. The parent or guardian could make their own appointment or drop-in on the official immunisation day during that week.
- The practice also allocated a nurse and assistant practitioner to each child. The practice completed a weekly search to ensure reminders were sent or direct contact made as appropriate, making the follow-up appointment at the time of the first immunisation and sending text reminders for immunisation to parents and guardians.
- 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 safeguarding lead was informed of all young people under 18 years who failed to be brought in or attend appointments with the GP or secondary care.
- 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 and were referred to a specialist service if required.
- 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	124	129	96.1%	Met 95% WHO based target

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)				
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)	127	133	95.5%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	127	133	95.5%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	125	133	94.0%	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>

Any additional evidence

Medicine fridges held two thermometers and a data logger as a failsafe to ensure the practice was alerted if the temperature of the fridges went above a safe temperature. The temperature of fridges was checked and recorded twice daily. It was noted that the temperature was recorded as above the required temperature on a single occasion and the reason recorded was that it had been an immunisation day. The nurses involved were aware of the importance of maintaining the cold chain and were confident that the fridge door had not been open for longer than the stipulated 20 minutes. Data logger information was not available for the period.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems linked to Public Health England (PHE) immunisation programme to ensure eligible patients received the meningitis vaccine.
- 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.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical	75.1%	N/A	80% Target	Below 80% target

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)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	64.2%	65.8%	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)	55.6%	51.7%	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)	58.7%	73.9%	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)	37.3%	42.2%	53.8%	Tending towards variation (negative)

Any additional evidence or comments

The practice was aware that the percentage of cancers detected early needed to increase. The practice was working as part of a pilot initiated by the Macmillan Cancer support to work with patients referred for investigation and those diagnosed with cancer. The practice held monthly meetings about palliative care patients with the community matron and Macmillan nurse specialist.

The practice was taking steps to improve cervical screening uptake; appointments were available at any time and the practice also had cervical screening appointments on Saturday mornings 9am to 12 mid-day.

The practice was aware that the data about the number of new cancer cases treated as a result of a two-week wait referral was lower than the national average. The practice provided unverified data provided by the local CCG indicating the practice was the 4th highest local practice for cases of cancer treated as a result of a two- week wait referral. The practice indicated referred patients using a Malignancy of Unknown Origin Pathway (MUO Pathway) where a cancer or malignancy might be indicated but the exact primary site was not known and the patient did not fit a defined two- week rule pathway referral and indicated these patients were not included in the two- week wait figures.

The practice had taken steps such as participating in public health campaigns to raise awareness of symptoms of possible cancer and reduce the behaviours which cause cancer. For example, weekly Fag Ends clinics were held at the surgery to help and encourage patients to give up smoking and the practice worked closely with the Community Respiratory team from Liverpool Heart and Chest (LHCH) to refer patients for a respiratory diagnosis.

GPs had also attended specialist courses run by the CCG.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances. The system involved four trained members of staff who logged all prescriptions and who collected them from the practice, all prescriptions were signed for and frequency of repeat prescriptions flagged. High risk medicines were not on repeat prescription at all and had to be reviewed by a GP .
- The practice reviewed patients at local residential homes.

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.
- 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. There were examples given of patients being referred to the specialist crises team as required.
- 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. All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and	100.0%	84.9%	89.4%	Significant Variation (positive)

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)				
Exception rate (number of exceptions).	26.2% (28)	10.7%	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)	100.0%	87.9%	90.2%	Significant Variation (positive)
Exception rate (number of exceptions).	12.1% (13)	9.3%	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)	72.0%	73.7%	83.6%	No statistical variation
Exception rate (number of exceptions).	26.5% (27)	7.3%	6.7%	N/A

Any additional evidence or comments

Exception reporting allows practices to exclude eligible patients from indicators or an entire clinical domain of the Quality and Outcomes Framework (QOF) when calculating success in achieving particular targets. It is expected that exceptions are kept as low as possible and the practice should understand the reasons for any exceptions. Data indicated that the practice excepted more patients from inclusion in the quality measure than national and local averages for mental health indicators. For example, the exception rates for care plans and face to face reviews of patients with dementia. All other exception rates were in line with or below local and national averages.

The high exception rates were discussed with members of the management team. The practice indicated that the exceptions were clinically justified because many patients with a psychosis were looked after by secondary care and care plans were completed and managed by those teams. In relation to patients with dementia, the practice had made a clinical decision to except patients who were on a palliative care treatment plan.

The management team indicated that their QOF data had been reviewed by the local CCG and no issues had been identified with regards to the data presented or exceptions made.

Monitoring care and treatment

The practice had a 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)	531.9	526.8	539.2
Overall QOF score (as a percentage of maximum)	95.1%	94.2%	96.7%

Overall QOF exception reporting (all domains)	3.8%	4.8%	5.9%
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	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Partial
Quality improvement activity was targeted at the areas where there were concerns.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

<p>Information about the most recent audits presented by practice</p> <ol style="list-style-type: none"> 1) February 2020 end of life audit was concluded and improvement actions proposed. There was no evidence seen of formalise dates for a second cycle to test the effectiveness of action taken. 2) February 2020 audit of prescribing of non-medical prescribers (NMP) set against an agreed prescribing list for NMPs as part of clinical supervision at the practice. The process identified areas for improvement and an action plan had been put in place and followed. A date for re-audit had not been identified. <p>Audits since the previous comprehensive inspection which had completed two cycles included.</p> <ol style="list-style-type: none"> 1) June and October 2016: Checking that patients prescribed a specific medicine had completed the required blood tests. Following the first cycle, action was taken to alert GPs to best practice guidance. The second cycle indicated an increase in patients having the required blood tests.

Effective staffing

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

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

employed since April 2015.	
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<ul style="list-style-type: none"> • The practice had developed a training matrix which highlighted when training was out of date. The matrix indicated the majority of administration staff were up-to-date with most mandatory training topics. Clinical staff however, were not update with mandatory some training. • Records indicated however, all clinical staff were up-to-date with their professional registrations and continual professional development requirements. Qualifications had been verified and professional registrations checked and recorded; and a process was in place to flag when these needed to be renewed. • Appraisal documents were comprehensive and appropriate for the role. • Agreed competency lists were in place. 	

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant	Yes

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

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	93.3%	95.6%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.3% (9)	0.6%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes
<ul style="list-style-type: none"> Administration staff had completed Mental Capacity Act and Deprivation of Liberty safeguards training and General Data Protection Regulation (GDPR) training. A patient pack was provided prior to them signing up for improved access such as electronic consultation or on-line services. The pack included a consent form, information about what information was required and reassurance about what would be shared; confirmation that staff and patients had different levels of access. 	

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels and demonstrated 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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
The practice had written a business plan which indicated workforce development including skill-mix; future development and potential succession operationally and clinically in the long term.	

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.	Yes
There was a realistic strategy to achieve their priorities.	Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Partial
<ul style="list-style-type: none">A written business plan had been developed and a copy of the Business Plan 2019-20 was provided at the inspection. This was based on national and local targets for primary care, as well as the needs of the practice population.The business plan did not include proposed timescales by which the targets would be achieved and the associated action plans were being developed.Staff had been involved with and informed about the development of the business plan and were able to articulate the values and plans of 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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
<ul style="list-style-type: none"> The majority of both clinical and administration staff had up-to-date equality and diversity training. Staff had been presented with lanyards printed with the values for them to refer to as required and these were also visible to patients and stakeholders. The practice had an employee notice board which was used to share information and staff could post ideas. There was a staff recognition programme for staff who were seen as going 'above and beyond'. Employees had access to a helpline provided by an outside agency. 	

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

Source	Feedback
Non-clinical staff	Staff had a clear understanding about their role and responsibilities to provide a safe and caring service for patients. Training opportunities were good and included on-line and face-to-face training opportunities. Staff were involved in social prescribing and sign posting patients for example: to a local choir or exercise classes. The administration staff also had information about how patients could access food banks.

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.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Partial
There were service level agreements in place for health and safety checks and aspects of servicing the building which was shared with other practices.	

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.	Yes
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<ul style="list-style-type: none"> • Policies and procedures for managing most risk areas were in place and an audit program to review compliance with being developed. • Some policies needed to be embedded for example, the prescription ordering, storage and use policy was newly introduced and the process for dealing with hand written prescriptions was not followed. • Some risks areas were managed informally for example, a policy for handling pathology results was not in place. Staff were clear about the actions required, which was to send a task to the GP who had made the request or to the duty GP. Searches indicated that recent pathology results had been dealt with in a timely manner. • There were service level agreements in place. It was noted that the clinical waste storage area was secure and could not be accessed by the public however, the lockable bins were overflowing with full bin bags so the bins could not be closed or locked. • This was discussed with the practice; it was stated that larger bins had been requested from the specialist waste disposal company but these had not been provided and a time-scale for solving 	

the problem had not been set.

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.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Partial
Any unusual access identified and followed up.	Yes
There were arrangements in place to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems. The documents were kept in a locked room which was only accessible to staff employed by the practice.	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<p>The practice responded to feedback from patients, for example, their score from the NHS patient satisfaction survey about ease of getting through to the practice was significantly lower than the local and national averages. The practice indicated that the telephone system which had been installed by the landlords only accommodated four lines which were fully staffed at the busiest times. However, to reduce the pressure on the system the practice had been one of the first to introduce electronic consultations and other online services which included booking appointments. The practice had also engaged with the local Healthwatch to interview patients about the changes and what worked well or needed to change.</p>	

Feedback from Patient Participation Group.

Feedback
<p>The patient participation group representative was complimentary about all aspects of engagement and indicated that the PPG was long established and routinely consulted about changes. Meetings were documented and either the senior partner or practice manager attended. The PPG representative indicated that in recent times accessing appointments had improved and additional means of communication had been introduced for example; TV screen; newsletters and posters. The PPG had been involved in designing and approving the practice leaflet.</p>

Any additional evidence

Stakeholders from residential and supported living services, including services for people with learning difficulties attended the inspection and indicated the practice was well organised in relation to attending to the needs of patients for example, learning disability health checks; flu vaccines, medicines management and caring for end of life patients.

Stakeholders indicated that:

- patients were treated with respect and treated as individuals by the GPs and nurses who visited them.
- referrals to secondary care were made efficiently.
- the practice was aware of and worked at providing the services needed in the local community.
- the practice worked collaboratively with secondary care and third sector providers such as charities as required.

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.	Yes
Learning was shared effectively and used to make improvements.	Yes

Examples of continuous learning and improvement

- The provider has introduced an electronic consulting programme following a pilot and was completing an assessment of the impact on patients.
- The practice has commenced working with a local pharmacist to opportunistically carry out a test which identifies patients who have a specific heart problem (atrial fibrillation) but who are symptom free. The practice identified that although recently commenced in February 2020 the project had been successful.

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)	≤ -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.