

Care Quality Commission

Inspection Evidence Table

Dr Rashmi Jain (1-503141925)

Inspection date: 25 February 2020

Date of data download: 18 February 2020

Overall rating: Good

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

Effective

Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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: <ul style="list-style-type: none">The practice used relevant and current evidence-based guidance, standards and practice to ensure effective care and treatment was delivered (this included from NICE and other expert and professional bodies).	

- Where relevant, they were completing local audits and patient searches to confirm the use of relevant evidence-based guidance, standards and practice. For example, a number of comprehensive medicines audit had been undertaken by the practice relating to best practice guidelines.
- All reception staff had received emergency and Sepsis training so that patients presenting with symptoms which could indicate serious illness, were followed up in a timely and appropriate way.

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>	0.49	1.03	0.74	No statistical variation

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Regular reviews were undertaken for patients living in local care homes.
- The practice followed up on older patients discharged from hospital. They 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 were offered to patients over 75 years of age, including those who were housebound. The practice had commenced a 'ring around' service for patients who were over 75 who had not attended the practice for over 12 months.
- Flu, shingles and pneumonia vaccinations were offered to all 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.
- 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 statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- 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) (QOF)	76.6%	82.2%	79.3%	No statistical variation
Exception rate (number of exceptions).	4.3% (11)	14.6%	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)	73.6%	81.1%	78.1%	No statistical variation
Exception rate (number of exceptions).	5.1% (13)	10.5%	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>	68.5%	81.9%	81.3%	Variation (negative)
Exception rate (number of exceptions).	6.7% (17)	15.8%	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>	64.8%	78.3%	75.9%	Variation (negative)
Exception rate (number of exceptions).	1.5% (6)	14.3%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	73.4%	92.6%	89.6%	Variation (negative)
Exception rate (number of exceptions).	5.9% (4)	15.1%	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)	68.5%	82.7%	83.0%	Significant Variation (negative)
Exception rate (number of exceptions).	1.3% (14)	4.6%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)	86.6%	92.8%	91.1%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	4.5%	5.9%	N/A

Any additional evidence or comments

The practice was aware that their target for achievement relating to some of the long-term conditions such as asthma, COPD, hypertension and diabetes were below local and national averages. The explanation given was the merger of two practices had been a very challenging time for the provider, data systems needed to be aligned and there were related problems that had impacted on the practice results. The practice also had a period without a practice nurse and they acknowledged problems relating to the coding of long-term conditions activities.

At the time of inspection, we found that new monitoring systems had been put into place and the leadership team had taken actions to address some of shortfalls. A new practice nurse had been recruited, increased diabetes training for staff had been undertaken and there was an increase in practice nurse time and appointments. A new recall system was planned for April 2020 and plans were in place for each of the GPs and nurses to take a lead role for one of the long-term conditions.

At the time of inspection unverified information from the new IT management systems was provided to show that the figures for the management of the above patient conditions had improved.

Families, children and young people

Population group rating: Good

Findings

- Safeguarding policies and procedures were in place.
- The practice had met all the minimum childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- 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.

- A dedicated young persons leaflet had been developed for young patients and notices were up in the reception area and on the practice website.
- 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)	47	48	97.9%	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)	50	51	98.0%	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)	50	51	98.0%	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)	49	51	96.1%	Met 95% WHO based target

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

Working age people (including those recently retired and students)

Population group rating: Good

Findings

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

Cancer Indicators	Practice	CCG average	England average	England comparison
-------------------	----------	-------------	-----------------	--------------------

The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (01/07/2019 to 30/09/2019) (Public Health England)	80.3%	N/A	80% Target	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	84.5%	75.4%	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)	67.0%	57.6%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) (PHE)	82.1%	63.8%	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)	30.8%	46.2%	53.8%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: **Good**

Findings

- An alert system was in place for vulnerable patients, including patient registers. Annual meetings took place with social services link workers to review the registers.
- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice had undertaken a detailed review of all of the last 20 patient deaths.
- 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 practice reviewed young 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.
- 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.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services. An in-house counselling session was available weekly at the practice and patients could be referred into this service.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	100.0%	95.6%	89.4%	Variation (positive)
Exception rate (number of exceptions).	4.0% (1)	12.0%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	65.2%	94.3%	90.2%	Variation (negative)
Exception rate (number of exceptions).	8.0% (2)	11.2%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	97.3%	81.1%	83.6%	Variation (positive)
Exception rate (number of exceptions).	5.1% (2)	6.6%	6.7%	N/A

Any additional evidence or comments

The practice was aware their achievement for the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was below local and national averages. We were told that this indicator was no longer monitored by QOF, but the practice had made to decision to review this going forward as part of the practice annual mental health review. At the time of inspection all patients had been invited to the practice for an annual review.

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)	455.7	546.7	539.2
Overall QOF score (as a percentage of maximum)	81.5%	97.8%	96.7%
Overall QOF exception reporting (all domains)	2.1%	6.7%	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

- There was evidence of good clinical audits being undertaken including how findings were actioned and reviewed. We found that quality improvement activity was targeted at areas where the practice had concerns. For example, audits for opiate and anti-biotic prescribing (Ciprofloxacin), minor operations, end of life care and high-risk medicine (Lithium) prescribing amongst others.
- Records showed that action plans were put into place following the audit and they were discussed at monthly staff meetings.
- The practice had a comprehensive audit plan for the year.
- Good systems were in place to monitor patient outcomes and trends in performance over a period. Meetings took place on a weekly basis to ensure ongoing oversight of clinical outcomes.

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.	Y
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had staff with the right qualifications, skills, knowledge and experience to do their job when they start their employment or took on new responsibilities and on a continual basis. There had been a high number of new members of staff recruited since the practice merger and systems were in development in terms of monitoring staff training. A training matrix had been developed along with a training plan. The practice manager was aware that further work needed to be done to align both practice records of training and the monitoring of this. Systems were in place to demonstrate how the practice assured the competence of staff employed in advanced clinical practice, for example, nurses and staff working in the practice dispensary. All new staff had completed an induction process which included identification of training needs, orientation to the service, and familiarisation of key policies was in place. Staff supervision arrangements were in place. All staff received annual and six-monthly appraisals during which time training needs and support were established. The practice manager was aware that a small number of staff had not had this completed and a plan was in place to address this. 	

- Staff had protected learning time to complete mandatory training. Staff we spoke with told us the practice was very good at supporting them to undertake additional courses for their ongoing training needs.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Effective links were in place for monitoring the needs of vulnerable patients and those with mental health needs. • Regular meetings took place with the district nursing teams. • The Gold Standard Support Framework was recently refreshed and supportive care registers (SCR) were set up and regularly reviewed. 	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice was proactive when identifying those patients that may need extra support. Staff we spoke with were supportive of patients being involved in managing and monitoring their own health needs. Information leaflets were provided for patients and sign posting to organisations that might be able to support patients. The practice worked with other multi-disciplinary team members, such as the district nurses and community matrons for those patients with more complex needs that require proactive care and support. 	

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>	94.5%	94.8%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.5% (8)	1.0%	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: <ul style="list-style-type: none">• All staff were aware of the Mental Capacity Act and what it meant for their role.• Staff we spoke with demonstrated a good understanding of 'best interests' decision making and when this was applicable.	

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: <ul style="list-style-type: none">• Practice leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it. They were knowledgeable about issues and priorities relating to the quality and future of the service.• The practice had merged with another practice nearby and so new practice management changes had recently been put into place. The new leadership team acknowledged the challenges they had faced bringing together two services and they were open and honest about problems they had encountered. Staff we spoke with were positive about how the changes had been implemented and the visible support they got from the leadership team.• The GPs and managers were contactable during the full operational period and staff knew how to contact them. The practice had a hierarchy of operational managers for all administration processes and this was working well at the time of inspection.	

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: <ul style="list-style-type: none">• The practice had a documented vision and strategy however, they acknowledged this needed to be reviewed and updated to include the new merged services. Plans were in place for protected	

time and financial support for this to take place as part of team building events.

- Decisions about how services were arranged and how they could develop was shared and discussed with all staff and patients via the practice Patient Participation Group (PPG).

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: <ul style="list-style-type: none"> • The practice had a Whistle Blowing policy in place and staff were aware of this and how to report any concerns they might have. This included the arrangements for staff to contact a named Freedom to Speak Up Guardian if needed. • Staff told us that the management team were open and encouraging of staff raising concerns and issues without their fear of the consequences. • Regular staff meetings took place also so that staff could raise issues, so they could be addressed, and actions taken to make improvements. • Significant events and patient complaints we reviewed showed there were systems to ensure compliance with the requirements of the duty of candour. 	

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

Source	Feedback
Staff	Staff stated they felt supported, this included support from other members of the team and the practice leadership team. They had access to the training they needed for their roles and were encouraged to develop their skills. Staff told us

	they were able to raise concerns and were encouraged to do so, they believed there to be an honest and open culture and they had confidence that should issues be raised they would be addressed. They told us there was good communication between all staff.
--	--

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Governance arrangements were proactively reviewed and reflected best practice. An annual quality improvement calendar had recently been developed, planning audits and reviews across the coming year. • Staff we spoke with were clear about their roles and who to go to for support. They described a supportive working environment. • An annual appraisal system was in place for all staff and at this time training was discussed related to how these roles might develop. A small number of appraisals remained outstanding and arrangements were in place for this to take place. • Comprehensive assurance systems were in place and evidence showed that performance issues would be escalated appropriately and acted upon. • The practice had effective oversight of the systems and processes and their own performance. Clinical audits and patients' reviews were completed in line with best practice guidelines. • The practice had a system for monitoring patient complaints. Overall, we found complaint handling processes were well managed with timely responses made to the complainants. Responses were open and transparent and when needed an apology was given. However, this information was not held in a central place and an annual review of complaints made was not carried out to identify themes and trends. • Patient safety risks were identified and managed well. • Performance reports were completed and submitted to the local CCG for monitoring. Patient records systems were in place ensuring the security and confidentiality of this information. 	

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: <ul style="list-style-type: none">• A system for recording and acting on significant events was in place and there was evidence of learning and dissemination of information when risks were identified.• A system was in place for ensuring all practice policies and procedures were monitored, reviewed and updated.• Staffing and employment risks were well managed by the practice. Leaders had planned for and achieved appropriate and safe staffing levels. Recruitment checks were carried out in accordance with regulations, however, there was no central system for this, so the presentation of this information did not show effective oversight.• There were effective arrangements for identifying, managing and mitigating risks. This included, safeguarding systems, processes and practices were developed, implemented and communicated to staff.• The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.• Information to deliver safe care and treatment was observed. Mostly this information was kept secure, however, a large number of patient records were not stored in safe lockable cupboards in line with current guidance and relevant legislation to reduce any risks.• The practice had systems for the appropriate and safe use of medicines, including the patient risks associated with these.• A major incident plan was in place. A business continuity plan was shown during the inspection	

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: <ul style="list-style-type: none"> Regular management and team meetings took place to review data and identify improvements for the practice. Our inspection indicated that information was accurate, valid, reliable and timely. Risk assessments were completed by the practice to identify manage and mitigate risks. For example, risks associated with the building and premises. 	

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: <ul style="list-style-type: none">• The practice had an active Patient Participation Group (PPG).• We found that patients' views and experiences were gathered and acted on to shape and improve the services. This included undertaking a practice patient survey and having discussions with the PPG about the findings of the survey.• We met with one member of the PPG and were told the practice listened to the group's suggestions, and they felt included in the running of the practice. We were told that the leadership team informed the group of any changes proposed and they sought their views for how services could improve. The PPG were in discussions with the leadership team about developing a practice newsletter, they told us the practice was very supportive of this.• Plans were in place to improve how the views of staff were reflected in the running of the service, at the time of inspection mostly this was carried out during regular team meetings.• The practice demonstrated positive and collaborative relationships with the newly formed primary care network. They spoke positively about the opportunities to build a shared understanding of challenges across the neighbourhood and in supporting each other to deliver services to meet those needs.	

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: <ul style="list-style-type: none">• The practice had taken part in pilots to improve the services offered to patients. For example, they worked closely with the diabetes specialist team for patients with complex needs. They also employed a pharmacist two days each week to support patients.	

- Vulnerable adults' registers were kept by the practice and monitored at monthly meetings. The practice also monitored those patients who were identified as having the potential for becoming vulnerable to ensure any changes in their circumstances were known by the practice.
- The practice worked closely with the CCG medicines management team on cost saving projects on a quarterly basis. The practice reviewed the service provided to patients and made changes to improve access. For example, the practice had introduced Econsult as a further way for patients to access clinicians.
- The leadership team had an inclusive approach to involving patients and staff.
- The practice was part of a primary care network (PCN) and was working within this to improve 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 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.