

Care Quality Commission

Inspection Evidence Table

Thorpewood Medical Group (1-604904604)

Inspection date: 6 & 7 February 2020

Date of data download: 5 February 2020

Overall rating: Requires Improvement

At our last inspection in July 2015 we rated the practice as Outstanding overall in line with our ratings aggregation principles. The provider was rated as outstanding for providing effective, responsive services and well-led services. We rated the provider as good for providing safe and caring services.

At this inspection we rated the practice as requires improvement overall.

We rated the practice as Requires improvement for providing safe services because the practice had not ensured the premises were safe for their intended purpose and had not ensured the proper and safe management of medicines.

We rated the practice as Requires Improvement for providing effective services as the practice exception reporting rates were significantly higher than local and national averages.

We rated the service as Requires Improvement for providing responsive services because patient feedback in the national GP patient survey was significantly below local and national averages for access to services. This affected all population groups and as such we rated all population groups as requires improvement.

We rated the practice as Requires Improvement for providing Well-led services as the practice did not have effective governance arrangements in place to identify and mitigate risks to staff and patients.

Safe

Rating: Requires Improvement

We rated the practice as requires improvement for providing safe services as the practice did not ensure the premises were safe for their intended purpose in relation to fire safety, we found poor storage and monitoring of vaccinations in the branch practice and the practice prescribing rates for broad spectrum antibiotic medicines were significantly higher than local and national averages.

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 took account of patients accessing any online services.	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: July 2017	Y ¹
There was a record of equipment calibration. Date of last calibration: July 2019	Y
There were risk assessments for any storage of hazardous substances for example, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks.	Y

Date of last check: April 2019 – annual inspection by a competent person and checked visually monthly.	
There was a log of fire drills. Date of last drill: Annual drill scheduled but not completed.	N ²
There was a record of fire alarm checks. Date of last check: 29 January 2020	Y ³
There was a record of fire training for staff. Date of last training: Annual – all staff up to date	Y
There were fire marshals.	Y ⁴
A fire risk assessment had been completed. Date of completion: July 2009 (last risk assessment by a competent person) July 2018 (last internal risk assessment)	Y ⁵
Actions from fire risk assessment were identified and completed.	Partial ¹
<p>Explanation of any answers and additional evidence:</p> <p>¹ The last fire risk assessment completed by a competent person in 2009 recommended that portable appliance testing should be carried out annually. The practice had moved to testing every three years, however there was no risk assessment for this decision.</p> <p>² The practice scheduled annual fire evacuation drills, however the last scheduled drill had not been undertaken as the person responsible for the drills had an unplanned absence from work and the responsibility had not been reassigned.</p> <p>³ The practice main site was not fitted with an automatic fire alarm activation system, however there were air horns situated throughout the building which staff knew to use in an emergency to raise the alarm. Horns were scheduled to be checked every six months, however checks had not been carried out during an unplanned absence from work as the responsibility had not been reassigned.</p> <p>There was no recent fire risk assessment to ensure these arrangements complied with current fire safety regulations.</p> <p>⁴ Fire marshals had been appointed, however these staff had not received specific training for the role. Following the inspection, the practice ensured training had been booked for fire marshals.</p> <p>⁵ Actions required from the last fire risk assessment by a competent person in 2009 had been completed. However, a recommendation that emergency lighting was checked annually by a competent person was not fully actioned. Weekly checks were carried out by a member of staff to ensure the lighting was operational however no annual safety checks by a competent person had been carried out and weekly internal checks were not carried out when the responsible person had an unplanned absence from work.</p> <p>At the branch site we found that fire safety arrangements were in place and risks managed by the building owners, including testing, drills and fire marshall provision.</p> <p>Following the inspection, the practice had scheduled a full fire risk assessment from an external agency specialising in fire safety.</p>	

Health and safety	Y/N/Partial
Premises risk assessment had been carried out. Date of last assessment: 22/01/2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 22/01/2020	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice provided staff health and safety training. There was an incident form and log sheet for staff to identify and escalate workplace health and safety concerns and we saw evidence action had been taken to address risks. A member of staff was responsible for carrying out monthly health and safety checks in the practice. We saw evidence these were recorded, and actions taken to address risks. However monthly checks had not been carried out when the person responsible for the checks had an unplanned absence from work as the responsibility had not been reassigned.</p>	

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: January 2020	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

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 had some systems for the appropriate and safe use of medicines, 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) (01/01/2019 to 31/12/2019) (NHS Business Service Authority - NHSBSA)	0.73	0.94	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). (01/01/2019 to 31/12/2019) (NHSBSA)	15.5%	9.2%	8.3%	Significant Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
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 (01/07/2019 to 31/12/2019) <small>(NHSBSA)</small>	6.42	5.93	5.58	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/07/2019 to 31/12/2019) <small>(NHSBSA)</small>	2.46	2.34	2.06	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
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.	Partial ¹
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.	Y

Medicines management	Y/N/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.	Partial ²
<p>Explanation of any answers and additional evidence:</p> <p>¹ The practice was aware of their higher than local and national average rates of prescribing of co-amoxiclav, cephalosporins and quinolones. The practice had identified which staff were the high prescribers and were working with them to reduce their use. However, there was little evidence to demonstrate any reduction in use.</p> <p>² We found out of date vaccines that were available for use at the branch site, however the practice explained it was unlikely these vaccines would be used as vaccines were transported from the practice main site for use in pre planned vaccine clinics. There were 12 vaccines which were out of date with the oldest expiry dates of August 2019. There was no procedure in place for routinely checking vaccines were safe to use, other than at the point of administering. Vaccines stored at the branch site were not in a specific medicines' fridge but in a domestic fridge. There was a thermometer in the fridge and temperature checks were recorded as being carried out daily, however there was no action recorded when temperatures went out of recommended ranges and no clear protocol for staff to follow in that situation. A data logger thermometer was also kept in the fridge, but it was unclear what happened with this information.</p> <p>The vaccines were removed and destroyed at the time of inspection and the practice told us they would source an appropriate medicines fridge.</p> <p>Vaccines were appropriately stored and effectively managed at the main site.</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:	16
Number of events that required action:	16

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

Event	Specific action taken
Wrong patient booked in for an appointment	Reception staff reminded to check more than one piece of patient identification and to confirm appointment details after booking.

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: Requires Improvement

We rated the practice as requires improvement for providing effective services for people with long term conditions and for people experiencing poor mental health (including people with dementia) as the exception reporting rates for people with asthma, COPD and some mental health conditions were significantly higher than local and national averages. The practice did not have systems in place to identify and remove barriers to these patients accessing care and treatment.

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

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2019 to 31/12/2019) (NHSBSA)	1.78	1.42	0.72	Variation (negative)

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> 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.

- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires Improvement

Findings

We rated this population group as requires improvement as the levels of exception reporting were significantly higher than local and national averages for people with the long-term conditions asthma and chronic obstructive pulmonary disease (COPD). At the time of inspection, the practice leadership team was not aware of this aspect of their performance and did not have plans in place to identify and remove barriers to patients accessing care and treatment.

We did however see examples of good care, including:

- Patients with long-term conditions, except for housebound patients, 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)	89.4%	82.4%	79.3%	Tending towards variation (positive)
Exception rate (number of exceptions).	22.2% (165)	17.9%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) (QOF)	82.8%	78.3%	78.1%	No statistical variation

Exception rate (number of exceptions).	13.2% (98)	14.3%	9.4%	N/A
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) (QOF)	83.3%	82.7%	81.3%	No statistical variation
Exception rate (number of exceptions).	19.2% (143)	18.9%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) (QOF)	73.9%	74.6%	75.9%	No statistical variation
Exception rate (number of exceptions).	23.3% (235)	8.6%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	96.7%	91.1%	89.6%	Tending towards variation (positive)
Exception rate (number of exceptions).	23.9% (47)	14.7%	11.2%	N/A
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)	81.0%	83.4%	83.0%	No statistical variation
Exception rate (number of exceptions).	3.5% (80)	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)	84.8%	92.0%	91.1%	No statistical variation
Exception rate (number of exceptions).	1.4% (4)	6.7%	5.9%	N/A

Any additional evidence or comments

At the time of inspection, the practice leadership team was not aware of the higher than local and national average exception reporting rate for patients with Asthma, COPD and some mental health conditions. Responsibility for the exception reporting process was held by the practice manager who was not available for the inspection. On investigation, the practice was able to explain the exception reporting process which had been changed in April 2018 to a text message based reminder system. Patients were sent three reminders in line with contractual obligations and then exception reported. There was no evidence of a system to identify patients who had been sent a reminder for a review so that they could be opportunistically booked in or the importance of the review discussed during other appointments or to verify patients had received text message reminders.

There was no provision for housebound patients to receive annual reviews for their asthma or COPD from the practice. These patients were automatically exception reported.

There was evidence that patients who attended for a review after they had been exception reported had not had their exception reporting removed. This was partly due to the exception reporting being conducted throughout the year and there not being a process in place to remove exception reports in this situation. This was being further investigated by the practice and the local clinical commissioning group.

At the same time that the exception reporting process had changed, the practice COPD specialist nurse had retired and the nurse responsible for asthma reviews took on the additional task of COPD reviews. This also contributed to the high number of patients not able to have their reviews completed.

The practice leadership team was not aware that any barriers to patients accessing care and treatment had been identified or removed.

Following the inspection the practice leadership team took action to review and improve the exception reporting process for 2019/20. For example, regarding asthma exception reporting, the practice found:

- Two hundred and forty-four exception reports had been processed for asthma patients following no response from three reminder text messages, including eight housebound patients.
- One hundred and fifty-six patients who had been sent three text message reminders were sent a letter reminder. Letters were to be the first reminder for patients requiring an annual review in the 20/21 QOF year, followed by three text messages. This was in line with good practice.
- Fifteen exception reports were removed after review as these patients no longer appeared on QOF registers and had not been prescribed any inhaler for more than a year.
- Thirty-two exception reports were removed as the patient had attended for a review since being exception reported. Future exception reporting would be completed at the end of the QOF year in line with good practice.

These changes and further improvements required implementation and evaluation to determine their effectiveness in removing barriers to patients accessing care and treatment.

Families, children and young people

Population group rating: Good

Findings

- The practice had met the minimum 90% for all four childhood immunisation uptake indicators. The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for one of four 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.
- 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)	115	120	95.8%	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)	118	126	93.7%	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)	118	126	93.7%	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)	119	126	94.4%	Met 90% minimum

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

Working age people (including those recently retired and students)

Population group rating: **Good**

Findings
<ul style="list-style-type: none"> 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	78.9%	N/A	80% Target	Below 80% target

period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 01/07/2019 to 30/09/2019) (Public Health England)				
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	77.1%	71.8%	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)	63.6%	58.7%	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)	70.5%	59.5%	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)	53.9%	48.9%	53.8%	No statistical variation

Any additional evidence or comments

The practice uptake rates for the cervical cancer screening programme were slightly below the target rate of 80%. We found that the practice had appropriate systems in place to allow access to the cervical cancer screening programme, including:

- Appropriate processes and procedures to govern the activity.
- Female sample takers who were trained for the role.
- Monitoring of the quality of sample taking and a failsafe results monitoring system.
- Appointments available at different times throughout the week to help working age people access the service.
- Non-attenders were sent a third reminder by the practice following the two reminders from the central screening programme office.
- Non-attendance was flagged on the patient record and screening was discussed opportunistically.

People whose circumstances make them vulnerable

Population group rating: **Good**

Findings

- 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 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.

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

Population group rating: Requires Improvement

Findings

We rated this population group as requires improvement as the levels of exception reporting were significantly higher than local and national averages for people experiencing poor mental health. At the time of inspection, the practice leadership team was not aware of this aspect of their performance and did not have plans in place to identify and remove barriers to patients accessing care and treatment.

We did however see examples of good care, including:

- 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.
- 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 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)	94.0%	90.5%	89.4%	No statistical variation
Exception rate (number of exceptions).	28.8% (34)	14.5%	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)	93.3%	92.6%	90.2%	No statistical variation
Exception rate (number of exceptions).	23.7% (28)	11.9%	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)	81.7%	82.4%	83.6%	No statistical variation
Exception rate (number of exceptions).	7.1% (8)	9.5%	6.7%	N/A

Any additional evidence or comments

At the time of inspection, the practice leadership team was not aware of the higher than local and national average exception reporting rate for patients with some mental health conditions. Responsibility for the exception reporting process was held by the practice manager who was not available for the inspection. On investigation, the practice were able to explain the exception reporting process which had been changed in April 2018 to a text message based reminder system. Patients were sent three reminders in line with contractual obligations and then exception reported. There was no evidence of a system to identify patients who had been sent a reminder for a review so that they could be opportunistically booked in or the importance of the review discussed during other appointments or to verify patients had received text message reminders. The practice leadership team was not aware that any barriers to patients accessing care and treatment had been identified or removed. The practice leadership team took action following the inspection to review and improve the exception reporting process for 2019/20. For example, by including a reminder letter in the process, completing exception reporting at the end of the QOF year. These changes and further improvements required implementation and evaluation to determine their effectiveness in removing barriers to patients accessing care and treatment.

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)	559.0	549.5	539.2
Overall QOF score (as a percentage of maximum)	100.0%	98.3%	96.7%
Overall QOF exception reporting (all domains)	7.3%	7.9%	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

The practice carried out an audit to assess the compliance of prescribing steroids for an inflammatory condition against NICE guidance on stomach protection for patients on regular steroids. The first audit cycle showed that of 38 patients prescribed steroids, nine were not offered appropriate stomach protection. The practice updated and refreshed clinician knowledge in this area, contacted patients to update their treatment and carried out a retrospective review six months later. The review showed that of the nine patients, all had been identified as not requiring stomach protection, but three patients were offered bone protection medicines.

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

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-centered care when they moved between 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	91.5%	94.9%	95.0%	Tending towards variation (negative)

other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) ^(QOF)				
Exception rate (number of exceptions).	0.5% (18)	0.6%	0.8%	N/A

Consent to care and treatment

The practice 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

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgmental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

CQC comments cards	
Total comments cards received.	19
Number of CQC comments received which were positive about the service.	19
Number of comments cards received which were mixed about the service.	Zero
Number of CQC comments received which were negative about the service.	Zero

Source	Feedback
CQC Comment cards	CQC Comment cards completed by patients showed staff were considered to be caring, friendly, listening, reassuring and supportive. GPs and nurses were named individually in some comments.
Patient feedback collected by the practice	The practice collated compliments received by patients. Compliments included how understanding and caring Doctors were, that nurses were helpful and efficient.
Patient interview	We spoke with one patient who told us they felt treated with compassion and respect by staff.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	80.5%	89.7%	88.9%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	79.8%	88.7%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	97.8%	96.6%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	69.5%	83.4%	82.9%	Tending towards variation (negative)

Any additional evidence or comments

The practice was aware of their lower than local and national patient satisfaction in some questions in the GP Patient survey.

The practice had recruited new staff including a GP and a receptionist and were recruiting for additional nursing staff. A new website was aimed at making online services easier to access and was part of a wider upgrade of the appointment booking system planned.

The practice was expecting to see patient satisfaction levels improve in the next GP patient survey.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y

Any additional evidence

The practice used a SMS system to communicate with patients which included patient feedback such as the NHS Friends and Family Test from which 89% of patients would recommend the practice.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

Source	Feedback
Interviews with patients and patient comment cards.	Patients felt the practice explained care and treatment well and took time to listen to concerns and explain medicine requirements. Patients felt involved in decisions about their care and treatment including options for where they would like to be referred.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	96.0%	95.4%	93.4%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 115 patients who were carers. This was approximately 0.8% of the practice population.
How the practice supported carers (including young carers).	The practice had a member of staff who identified and directed carers to the various avenues of support available. Carers received a support information pack and an annual letter from the practice inviting them for a flu vaccination and to ensure practice records were up to date. Carers were referred to the West Norfolk Carers group for further help and support.

How the practice supported recently bereaved patients.	Recently bereaved patients received a call from the practice offering support and appointments at an appropriate time and place. There were processes in place to update records and inform staff.
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Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive

Rating: Requires Improvement

We rated the practice as requires improvement for providing responsive services as data from the national GP patient survey was significantly below local and national averages for indicators relating to accessing services. Whilst the practice had put actions in place to improve access, these changes required embedding and evaluation to determine their effectiveness. These issues affected all population groups.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	
The service did not offer annual reviews for housebound patients with asthma or COPD, however the practice did utilise the services of a local home visiting service to attend housebound patients with urgent needs and there was work underway to extend the scope of the home visiting service to include routine and review appointments.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	8am – 11.30am and 2pm – 5pm
Tuesday	8am – 11.30am and 2pm – 5pm
Wednesday	8am – 11.30am and 2pm – 5pm
Thursday	8am – 6.30pm
Friday	8am – 11.30am and 2pm – 5pm

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	98.1%	95.6%	94.5%	Tending towards variation (positive)

Older people

Population group rating: Requires Improvement

Findings

We rated the practice as requires improvement for providing responsive services as data from the national GP Patient survey was significantly below local and national averages in relation to accessing services. These issues affected all population groups including this one. However, we did see areas of good practice including:

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.

People with long-term conditions

Population group rating: Requires Improvement

Findings

We rated the practice as requires improvement for providing responsive services as data from the national GP Patient survey was significantly below local and national averages in relation to accessing services. These issues affected all population groups including this one. However, we did see areas of good practice including:

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services, with the exception of those housebound patients with asthma or COPD who were not able to receive annual reviews.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Requires Improvement

Findings

We rated the practice as requires improvement for providing responsive services as data from the national GP Patient survey was significantly below local and national averages in relation to accessing services.

These issues affected all population groups including this one. However, we did see areas of good practice including:

- Additional nurse appointments were available for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Parents with concerns regarding children under the age of 10 could attend a drop-in clinic held at the same time as the twice weekly baby clinic.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

We rated the practice as requires improvement for providing responsive services as data from the national GP Patient survey was significantly below local and national averages in relation to accessing services. These issues affected all population groups including this one. However, we did see areas of good practice including:

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Pre-bookable appointments were available to all patients at the practice and additional locations within the area, as the practice was a member of a primary care network. Appointments were also available Saturday mornings.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

We rated the practice as requires improvement for providing responsive services as data from the national GP Patient survey was significantly below local and national averages in relation to accessing services. These issues affected all population groups including this one. However, we did see areas of good practice including:

- The practice held a register of patients living in vulnerable circumstances such as homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health

Population group rating: Requires Improvement

(including people with dementia)

Findings

We rated the practice as requires improvement for providing responsive services as data from the national GP Patient survey was significantly below local and national averages in relation to accessing services. These issues affected all population groups including this one. However, we did see areas of good practice including:

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

People were able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y

Indicator	Practice	CCG average	England average	England comparison
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 (01/01/2019 to 31/03/2019)	47.9%	N/A	68.3%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	50.7%	68.3%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	36.3%	67.4%	64.7%	Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the	59.1%	76.0%	73.6%	Tending towards variation (negative)

Indicator	Practice	CCG average	England average	England comparison
type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)				

Any additional evidence or comments

The practice was aware of their lower than local and national performance in some questions in the GP Patient survey. The practice felt this was a result of the patient experience of making appointments over the phone. The practice had upgraded the telephone system and had seen a reduction in the number of complaints and comments related to the appointment system.

The practice had also recruited new staff including a GP and a receptionist and were recruiting for additional nursing staff. A new website was aimed at making online services easier to access and was part of a wider upgrade of the appointment booking system planned.

The practice were expecting to see patient satisfaction levels improve in the next GP patient survey.

Source	Feedback
Patient comment cards patient interview	<p>Patients told us that they could sometimes wait for a routine appointment with a specified GP but that they could get an urgent appointment when they needed one or a routine appointment with any GP more quickly.</p> <p>Patients did not feel rushed during appointments and felt staff were good at listening.</p>

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	42
Number of complaints we examined.	Four
Number of complaints we examined that were satisfactorily handled in a timely way.	Four
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Zero
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
Explanation of any answers and additional evidence: The practice recorded all complaints including formal complaints and informal complaints and verbal comments and suggestions. Each was valued as a learning opportunity. The practice used call recording technology to review and improve patient experiences and staff learning and development.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Screens were not updated informing patients of a delay in appointments.	Processes were put in place to update the screens and staff were reminded of informing patients of delays.
Patient received a letter saying they did not attend for an appointment.	The practice reviewed and found that the error was theirs and that the appointment had been rebooked and the original not cancelled. The practice apologised and it was brought to the attention of all staff as a reminder.

Well-led

Rating: Requires Improvement

We rated the practice as Requires Improvement for providing Well-led services as the practice did not have effective governance arrangements in place to identify and mitigate risks to staff and patients.

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.	Partial
They had identified the actions necessary to address these challenges.	Partial
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: Leaders took action to manage challenges to quality and sustainability. This included managing staff where performance and conduct were below standards expected. Recruiting clinical and non-clinical staff to key roles to address demand and capacity issues, investing in technology to improve patient experiences and supporting the development of staff internally. However, the practice leadership team did not have enough oversight of the roles and responsibilities of key staff and there were no effective arrangements in place to transfer roles and responsibilities when key staff were absent.	

Vision and strategy

The practice had a clear vision and 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.	Partial
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.	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.	Partial
Explanation of any answers and additional evidence: The practice had a clear vision and strategy to provide high quality sustainable care, however the practice had not monitored the delivery of the strategy effectively, resulting in lower quality care being provided to some population groups. The new practice leadership team had set out clear actions to achieve priorities and staff were fully engaged in delivering their roles and responsibilities, however more time was needed to ensure the aims of improving patient care were achieved.	

Culture

The practice had a culture to provide high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y ¹
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: ¹ The practice had effective procedures in place for identifying poor performance, including listening to staff concerns. We saw effective escalation of measures where these were necessary. The practice leadership team recognised when to seek external advice and guidance when managing performance concerns. They had sought the services of an external HR company in a recent example. Staff told us they valued the independent support of this service and the responsiveness of the practice leadership team, including the restructure of the practice leadership team.	

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

Source	Feedback
Staff interviews	Staff were happy and proud to work in the service. They felt supported by their immediate line managers and the practice leadership team. Staff valued the recognition the practice offered them with training and development opportunities. Staff felt there was better communication and stronger lines of accountability and responsibility since the restructure of the practice management team.

Governance arrangements

Responsibilities, roles and systems of accountability to support good governance and management were not always effective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Partial

Explanation of any answers and additional evidence:

Key staff in the practice were assigned or took on roles and responsibilities without formal oversight from partners. When key staff were not available, their roles and responsibilities were not transferred. This meant that some safety and quality arrangements lapsed or were not effectively managed.

The practice leadership team had effectively managed performance issues and had restructured the practice leadership team to include clinicians, partners and non-clinical managers. The leadership team were confident, and we saw evidence that, they had better oversight of the management of the service at the time of our inspection. However, these new leadership arrangements required embedding and evaluation to ensure their effectiveness.

Managing risks, issues and performance

Processes for managing risks, issues and performance were not always clear and effective.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N ¹
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y ²
There were effective arrangements for identifying, managing and mitigating risks.	N ³
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 ⁴

Explanation of any answers and additional evidence:

¹ Assurances were sought from key staff regarding their roles and responsibilities, however there was no formal monitoring system to verify these assurances or to be able to effectively manage performance in key areas during key staff absences.

² There was a programme of clinical and non-clinical audit to monitor internal and external performance factors, guidelines and best practice compliance and quality monitoring, however these audits did not highlight significantly higher than average exception reporting rates for some clinical QOF indicators as the exception reporting programme did not have effective leadership oversight.

³ There arrangements in place for identifying, managing and mitigating risks in the practice however these systems were not always effective as they did not continue when responsible staff were absent. Staff responsible for identifying fire safety risks had not been trained for the role and effective vaccine storage and monitoring arrangements in the main practice did not extend to the branch site.

⁴ The practice leadership team had carried out a capacity and demand audit. This helped them to assess the staffing requirements in the practice, including recruiting six administrative staff to replace four who had left the practice.

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: At the time of inspection, the practice leadership team was not aware of the higher than local and national average exception reporting rate for patients with some mental health and long-term conditions in the 2018/19 QOF year. The practice took action to investigate and make changes to the exception reporting system for the 2019/20 QOF year, however further improvements, including oversight and assurance systems, required embedding and evaluation to determine their effectiveness.	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial ¹
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.	Partial ²
Explanation of any answers and additional evidence: ¹ The practice had acted on patient views to improve services, however more time was needed for these changes to be embedded and any improvements evaluated for effectiveness. ² The practice had engaged with local commissioners to improve services for housebound patients, however more needed to be done to identify and remove barriers to patients accessing care and treatment.	

Feedback from Patient Participation Group.

Feedback
The patient participation group told us there was good engagement with the practice and that they felt the practice were open and honest. The PPGs views were sought when the practice faced challenges and where improvements were required, including the new telephone system.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Y

Explanation of any answers and additional evidence:

There was a strong focus on the development of staff. The practice management restructure brought in new levels of management allowing staff with particular skills, interests and abilities to develop into management roles. Staff valued the level of training and development opportunities which were key parts of regular appraisals and development reviews. However, more needed to be done to ensure there were effective governance structures in place to ensure continual improvement of the care and treatment patients received.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.