

Care Quality Commission

Inspection Evidence Table

St Ann's Medical Centre (1-542394532)

Inspection date: 10 March 2020

Date of data download: 11 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. However, performance data for cervical cancer screening was significantly below local and national averages.

	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: The practice implemented a new patient record system in November 2018 that impacted on Quality Outcomes Framework attainment for 2018/19. Further detail can be found below for each population group.	

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) <small>(NHSBSA)</small>	0.76	0.75	0.72	No statistical variation

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 as soon as vaccine stock was received.

People with long-term conditions

Population group rating: Good

Findings
<ul style="list-style-type: none"> The practice was able to offer a reasonable explanation as to why performance attainment for this patient population group was lower than local and national averages and had taken steps to address this. As a result unverified data for 2019/20 showed an improvement in the management of the majority of long term conditions although some still remained below local and national averages. We were assured during the inspection that attainment had been impacted by a change to the practice computer system and coding issues rather than a failure to monitor patients with long term conditions effectively. 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) <small>(QOF)</small>	64.1%	73.6%	79.3%	Variation (negative)
Exception rate (number of exceptions).	4.1% (52)	6.8%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	58.2%	74.1%	78.1%	Variation (negative)
Exception rate (number of exceptions).	3.8% (48)	6.0%	9.4%	N/A

Any additional evidence or comments

The practice historically had a lower achievement in diabetes outcomes since March 2018. Changes to the GP record keeping system were implemented in November 2018, mid-way through this QOF 2018/19 data collection year. This had an impact on the QOF outcomes as different codes and pathways were used. We reviewed several patient records for patients with diabetes and saw that documentation was extensive of the care provided and reviews and tests were undertaken as appropriate. The provider told us staff discussed the appropriate use of codes at clinical meetings. In addition, the recall system was reviewed, and a clinical decision support tool implemented to standardise procedures and clinical pathways.

The practice shared with us the unverified QOF outcomes for diabetes for the year 2019/20 which was 49.6 out of 70 points available (71%).

At the time of inspection, the practice had three practice nurse vacancies and existing nursing staff were undertaking further training to perform diabetes reviews with patients. Patients identified at high risk of developing diabetes were referred to the national diabetes prevention programme.

	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	71.7%	80.2%	81.3%	Tending towards

months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>				variation (negative)
Exception rate (number of exceptions).	5.0% (64)	8.8%	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>	65.4%	73.1%	75.9%	Variation (negative)
Exception rate (number of exceptions).	1.8% (21)	4.2%	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 dyspnea scale in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	70.2%	82.3%	89.6%	Significant Variation (negative)
Exception rate (number of exceptions).	2.9% (20)	6.8%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	72.9%	83.0%	83.0%	Variation (negative)
Exception rate (number of exceptions).	1.8% (49)	2.5%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) <small>(QOF)</small>	88.6%	90.5%	91.1%	No statistical variation
Exception rate (number of exceptions).	4.1% (15)	4.9%	5.9%	N/A

Any additional evidence or comments

The practice historically had a lower achievement in COPD outcomes since March 2018. Changes to the GP record keeping system were implemented in November 2018, mid-way through this QOF 2018/19 data collection year. This had an impact on the QOF outcomes as different codes and pathways were used. We reviewed several patient records for patients with asthma and COPD and saw that documentation was extensive of the care provided and reviews and tests were undertaken as appropriate. The provider told us staff discussed the appropriate use of codes at clinical meetings. In addition, the recall system was reviewed, and a clinical decision support tool implemented to standardise procedures and clinical pathways.

The practice shared with us the unverified end of year QOF outcomes for 2019/20 which showed that:

- For diabetes related indicators they had attained 49.6 out of 70 available points (71%)
- For asthma they had attained 44.8 out of 45 points (100%)
- For COPD they had attained 18.7 out of 25 points (75%)
- For hypertension they had attained 19 out of 25 points (76%)
- For atrial fibrillation they had scored all the points 29 points (100%)

These results demonstrated improvement in most areas.

At the time of inspection, the practice had three practice nurse vacancies and existing nursing staff were undertaking further training to perform asthma and COPD reviews with patients. Patients diagnosed with lung conditions were also referred to local groups for further advice and support.

Families, children and young people

Population group rating: Good

Findings

- The practice has met the national minimum target of 90% for all of four childhood immunisation uptake indicators but had not achieved the World Health Organisation (WHO) target of 95%
- 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. A dedicated member of staff had oversight of and tracked all the safeguarding processes. The practice followed the local guidance for children who did not attend any appointment, this was audited and cases discussed at clinical meetings.
- 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)	183	198	92.4%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received	168	183	91.8%	Met 90% minimum

Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)				
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	168	183	91.8%	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)	167	183	91.3%	Met 90% minimum

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

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings
<ul style="list-style-type: none"> Practice staff were aware of the lower achievement for cervical cancer screening and number of new cancer cases treated. 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). (Snapshot date: 31/12/2019) (Public Health England)	70.5%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	68.7%	74.4%	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)	48.0%	57.5%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as	48.6%	65.8%	68.1%	N/A

occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) ^(PHE)				
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)	39.3%	49.4%	53.8%	Tending towards variation (negative)

Any additional evidence or comments

The practice was aware of the lower achievement with cervical cancer screening outcomes. Reminders were posted to patients on pink paper to attract attention and staff contacted patients by telephone to remind them of the importance of screening. Patients were also offered cervical cancer screening appointments at one of the extended hours hubs in the evening and at weekends. Voluntary action groups held regular sessions in the practice waiting rooms promoting the importance of cancer screening initiatives and provided information and leaflets for patients to take away and read.

Practice staff had identified the lower number of new cancer cases treated and as a result had convened a monthly meeting to specifically review all cancer diagnosis, referrals made and the care provided to the patient. Community staff were invited to the meeting and patient records were updated at the meeting. From the records we reviewed we saw that care was provided to the patient, however it was not always coded.

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.
- 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 provided unverified performance data for 2019/20 showing an improvement in the management of the dementia and mental health issues.
- From the records we reviewed we saw that staff 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. To assist improvement a GP took the lead

mental health in the practice and held specific clinics for patients to attend when other support services were available in the practice.

- Same day and longer appointments were offered when required.
- Staff worked closely with the local mental health services who also held regular clinics in the practice to review patients.
- 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.

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)	60.2%	82.2%	89.4%	Significant Variation (negative)
Exception rate (number of exceptions).	0.8% (2)	7.2%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	71.4%	87.8%	90.2%	Variation (negative)
Exception rate (number of exceptions).	0.0% (0)	3.9%	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)	89.4%	86.2%	83.6%	No statistical variation
Exception rate (number of exceptions).	3.8% (9)	5.7%	6.7%	N/A
Explanation of any answers or additional evidence:				
The practice shared with us the unverified QOF outcomes for 2019/20 which showed that:				
<ul style="list-style-type: none"> • For dementia they had attained 44 out of 44 available points (100%) • For mental health indicators they had attained 15.6 out of 18 available points (87%) 				
These results demonstrated improvement in relation to mental health outcomes.				

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)	473.1	529.9	539.2
Overall QOF score (as a percentage of maximum)	84.6%	94.8%	96.7%
Overall QOF exception reporting (all domains)	3.0%	4.7%	5.9%
The practice shared with us the unverified QOF outcomes for 2019/20 which showed that they had attained 91% of the total points available.			

	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

<p>Several Clinical audits had been completed including:</p> <ul style="list-style-type: none"> An audit of patients with heart conditions taking medicines that required regular review. The aim was to determine if patients were having regular reviews and blood tests performed. The audit identified several patients that required a further blood test which was then performed. Weekly searches of patients were then performed for these patients to ensure investigations and review appointments were undertaken. The practice audited the outcomes for patients attending the in-house physiotherapy clinic. The audit identified the conditions the patient was most likely to attend the appointment with and those conditions where providing further information for the patient was beneficial.

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
Explanation of any answers and additional evidence:	
<p>The practice had a six-month induction programme for all staff. Those we spoke with said this was a supportive approach and equipped them opportunity to develop additional skills for the role.</p> <p>The practice employed an emergency care practitioner paramedic who reviewed patients in the practice and performed home visits. Care navigation staff were clear about which conditions the advanced nurse practitioner and emergency care practitioner paramedic could see and booked patients into appropriate appointments.</p>	

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:	

Reception staff were trained in care navigation and answered telephone calls to the practice in a hub at the main site. Visual posters were used as prompts for staff to navigate patients to the most appropriate outcome for their needs. Feedback from patients and other services was positive about how patients were directed to appropriate services.

Helping patients to live healthier lives

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

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

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	91.3%	95.3%	95.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	0.6% (27)	0.6%	0.8%	N/A

Any additional evidence or comments

Smoking cessation was offered locally and practice staff signposted patients to these services and provided health information about the benefits of stopping smoking. Staff proactively asked patients their smoking status when they came in contact with the practice.

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

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: Leaders identified the challenges that faced the practice and had acted to address them. Succession planning was key to the success of the practice and supporting new staff in their roles. The practice had successfully recruited new additional roles, such as the pharmacist and emergency care practitioner, who provided care to patients. Trainees at the practice highly evaluated their placements and often choose to take up permanent posts there.	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: The practice had a vision that was regularly reviewed as part of their ongoing strategy. Staff told us they were clear of their roles and responsibilities and how they contributed to the vision and strategy. The practice was also an active member of the local primary care network with a practice GP being the Clinical Director.	

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:	
<p>The practice used innovative ways to promote staff motivation and support well-being. For example, all patient feedback was shared with staff as part of 'Feedback Fridays' and staff were given an additional day off on their birthday.</p> <p>Staff identified areas for improvement and roles were expanded to accommodate new ways of working. For example, a member of the administrative team took the lead for oversight of safeguarding processes. Practice nurses were encouraged to undertake further training in sexual health to provide advice to patients.</p>	

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

Source	Feedback
Interviews with staff	<p>Excellent supportive and encouraging place to work enabling the best care for patients. Staff were encouraged to feedback where things could be improved to provide even better services to patients.</p> <p>Staff we spoke with told us there was an open, supportive and transparent culture within the practice. Staff worked well together and they felt comfortable raising concerns as they knew they would be acted upon.</p>

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

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

Managing risks, issues and performance

There were effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: The practice review also identified a high level of complaints from patients which were not themed into categories. This was undertaken and as a result, further customer care training was delivered to staff and care navigation implemented. A telephone call auditing tool was introduced in 2018 to measure the effectiveness and quality of the calls answered at the practice. The results from 2018 demonstrated that 79% of calls audited met the required competencies, whereas the most recent audit in March 2020 demonstrated all the competencies were met. In addition, the number of complaints to the practice had significantly reduced from 24 in 2018 to eight in 2019.	

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: The practice used a telephone call monitoring board to visualise the number of telephone calls coming into the practice and the number of staff available to answer the calls which was adjusted to meet demand.	

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: Following management changes, a whole practice review was undertaken. Areas for improvement were implemented as part of the practice improvement programme. As part of this the practice identified further engagement with patients was required. A Patient Engagement Officer role was introduced and tasked with coordinating patient feedback. As a result of feedback from patients, a six-month probation period was introduced to support and mentor new staff. Staff told us they found this approach very supportive. The practice produced a quarterly newsletter for staff to keep them up to date with good news stories and changes within the practice. Feedback from patients was overwhelmingly positive about being cared for at the practice. The main 'grumbles' were that clinics occasionally did not run to time.	

Feedback from Patient Participation Group.

Feedback

The patient participation group met quarterly and guest speakers were invited to inform and promote practice and community initiatives. Members were engaged with the practice and the group were actively seeking new members. The group met with the patient participation group from another GP practice based in the building twice a year.

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:	
The practice received positive feedback from the physiotherapy service on the number and quality of appropriate referrals made to the service. Feedback enabled the improvement of the service for patients.	
The practice were proactive introducing call reviews for reception staff to improve patient satisfaction.	

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:

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.