Care Quality Commission

Inspection Evidence Table

Salisbury Medical Practice (1-1192900347)

Inspection date: 20 November 2018

Date of data download: 16 October 2018

Please note: Any Quality Outcomes Framework (QOF) data relates to 2016/17 except where stated otherwise.

Safe

Safety systems and processes

Safeguarding	Y/N
There was a lead member(s) of staff for safeguarding processes and procedures.	Yes
Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Policies were in place covering adult and child safeguarding.	Yes
Policies were updated and reviewed and accessible to all staff.	Yes
Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs)	Yes
Information about patients at risk was shared with other agencies in a timely way.	Yes
Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients	Yes
Disclosure and Barring Service checks were undertaken where required	Yes

Further information:

The practice promoted the importance of safeguarding by providing staff with some key information they kept with their identification smartcard.

The practice had systems to highlight vulnerable patients on their register. For example, one the day of our inspection this system identified; seven patients who were homeless, 259 veterans, 152 patients with learning difficulties, 1861 patients aged 75 and over, and 549 carers.

The practice told us they had reorganised their whole staff structure, this included the clinical and administration and reception teams. Specialist teams had been set up to improve quality and standards. A recent audit of these arrangements had found some issues. One aspect of this was the practice had identified an improved electronic training log was required. At the time of inspection, the practice was in the process of transferring paper refresher systems onto the electronic log and scanning certificates against the log.

The electronic log showed some staff had not completed their refresher Child Safeguarding Training to the appropriate level. We also noted two nurses, two GPs and two administrative/ reception team members had not completed the appropriate refresher training. The refresher update was based on a cyclical review process. At the time of inspection all members of staff were within this timescale. As part of the recent improvements to the service the practice has amended their safeguarding training requirements to reflect whether this training was being carried out as face to face or whether it was a combination of online and CPD. The practice considered this to be a more robust process. The new electronic system had been amended to show the revised dates, which are different depending on the method of training.

Recruitment Systems	Y/N
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Yes
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Staff who require medical indemnity insurance had it in place	Yes

Safety Records	Y/N
There was a record of portable appliance testing or visual inspection by a competent person Date of last inspection/Test:	Yes 24/1/2018
There was a record of equipment calibration Date of last calibration:	Yes 24/1/2018
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	Yes
Fire procedure in place	Yes
Fire extinguisher checks	Yes
Fire drills and logs	Yes
Fire alarm checks	Yes
Fire training for staff	Yes
Fire marshals	Yes
Fire risk assessment Date of completion	Yes June 2017

Actions were identified and completed.	Yes
Health and safety Premises/security risk assessment? Date of last assessment:	Yes March 2018
Health and safety risk assessment and actions Date of last assessment:	Yes March 2018

Infection control	Y/N
Risk assessment and policy in place	Yes
The arrangements for managing waste and clinical specimens kept people safe?	Yes

Risks to patients

Question	Y/N
There was an effective approach to managing staff absences and busy periods.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans were developed in line with national guidance.	Yes
Staff knew how to respond to emergency situations.	Yes
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.	Yes
In addition, there was a process in the practice for urgent clinician review of such patients.	Yes
The practice had equipment available to enable assessment of patients with presumed sepsis.	Yes
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Yes

Information to deliver safe care and treatment

Question	Y/N
Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented.	Yes
The practice had a documented approach to the management of test results and this was managed in a timely manner.	Yes
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.	Yes

Appropriate and safe use of medicines

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) (01/07/2017 to 30/06/2018) NHS Business Service Authority - NHSBSA)	0.80	0.93	0.95	Comparable with other practices
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). (01/07/2017 to 30/06/2018) (NHSBSA)	10.3%	11.0%	8.7%	Comparable with other practices

Medicines Management	Y/N
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.	Yes
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Yes
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, audits for unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were systems for the safe ordering, checks on receipt, storage, administration, balance checks and disposal of these medicines in line with national guidance.	Yes
Up to date local prescribing guidelines were in use.	Yes
Clinical staff were able to access a local microbiologist for advice.	Yes
For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance.	Yes
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	Yes
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Yes
There was medical oxygen on site.	Yes
The practice had a defibrillator.	Yes
Both were checked regularly and this was recorded.	Yes

Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Partial (see below for further information)

Explanation of any answers:

Two weeks prior to our inspection the practice recorded a significant event in relation to the vaccine fridge, when the internal air temperature reached 25 degrees Celsius. (Vaccines are usually kept at a temperature between four to eight degrees Celsius.) The practice did an investigation and raised a significant event. Their investigation showed the increase in temperature was caused by the fridge door being left open 20 minutes before the fault was noticed. They sent an alert to all staff regarding the incident and identified that further training was required for the staff responsible. They concluded there was no risk to the vaccines and this was subsequently confirmed by the vaccine manufacturers.

On the day of our inspection the practice found the vaccine fridge maximum and minimum temperature record, which should be reset every day after the reading has been recorded, had not been reset since the previously incident. The record of actual fridge temperatures recorded daily were all stable and within the required temperature range. The practice updated the significant event and identified that further training and policy guidance was required. The practice told us the training requirement previously identified had not been completed due to their preparations for our inspection.

Track record on safety and lessons learned and improvements made

Significant events	Y/N
There was a system for recording and acting on significant events	Yes
Staff understood how to report incidents both internally and externally	Yes
There was evidence of learning and dissemination of information	Yes
Number of events recorded in last 12 months.	66
Number of events that required action	12

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

Event	Specific action taken
Vaccine Fridge door left open for 20 minutes leading to internal air temperature reading going out of recommended range (4 – 8 degrees Celsius.	Staff reminded of importance of keeping fridge doors closed. Further training needs identified. Policy and protocol update required.
Patient requested a prescription for a minor tranquiliser to help overcome anxiety regarding a medical procedure being carried out by a clinician not connected to the practice. The practice initially refused the request but subsequently prescribed.	The practice agreed it would help to have a policy to cover this and similar requests. A policy was written and shared with clinicians.

Any additional evidence
The practice had an open and transparent approach to significant events. Learning points were shared with appropriate staff using a variety of methods. They were initially discussed in staff meeting and learning points were often included in staff newsletters. However, there was no clear system for ensuring all appropriate staff were informed of the learning points, such as those unable to attend meetings. The practice had undertaken a review of their significant events to look for themes and trends. Following the inspection, the practice advised us of the following actions in support of sharing learning from significant events. • As part of the two-week staff induction process staff were shown where information was stored within the practice computer system. • All staff were advised at Induction that if they cannot attend a meeting they must keep up to date with information that was placed on the practice system. This includes the outcomes from significant events. • The practice had a two-year communication and engagement strategy which ensured that all systems of communication were under continuous review to improve quality and standards. We have been unable to verify the evidence of this submission as no further information to demonstrate these actions was received.

Safety Alerts	Y/N
There was a system for recording and acting on safety alerts	Yes
Staff understand how to deal with alerts	Yes
Comments on systems in place: There was system in place for recording and acting on safety alerts. We looked the actions taken for three alerts and found the practice had taken all appropriate action. However, we found the practice had no clear system for staff taking the actions required, to report back to a central point to confirm all actions had been completed.	

Effective

Note: When we inspected the practice the practice performance data for the 12 month period 01/04/2017 to 31/03/2018 was not available to us so we used the data from the previous 12 month period (01/04/2016 to 31/03/2017) to inform our inspection. However, a few days after the inspection the more recent data become available and it is included here for information purposes. This more recent data is highlighted in yellow.

Effective needs assessment, care and treatment

Prescribing				
Indicator	**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) (01/07/2017 to 30/06/2018) (NHSBSA)	0.89	0.82	0.83	Comparable with other practices

Older people — Population group rating: Outstanding

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice had regular multi-disciplinary meetings (MDT) where patient care was reviewed and care plans implemented.
- 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.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks were offered to patients over 75 years of age.
- The practice had designed, led and employed staff for an innovative elderly care service. They collaborated with other local practices to expand the team, continued the management and development of the team to provide services for all the participating practice patients, resulting in a single team covering care in 20 care homes for planned and acute visits and for the provision of domiciliary visits for the over 75's. The nurse led team delivered stratified health care through a team of GPs, specialist nurses, nurses in development posts, nurse associates. Integrated into the team was a seconded Age UK Living Well Manager, who supported patients to manage their own health, (data shows this reduces one hour of GP appointments per patient per year), a seconded Safe and Independent Living Advisor from Wiltshire and Dorset Fire Brigade supporting the safe and warm, several care co-ordinators supporting patients to manage care pathways and a sign-poster to integrate patients with voluntary services within the area.
- Older patients who are identified as frail or vulnerable receive a full assessment of their physical, mental and social needs, including a review of their medication. The team provided a single point of contact for care home staff, with the aim of removing variation of care provision between care homes by GP surgeries.

People with long term conditions

Population group rating: Requires Improvement

Indicator	Practice performance	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 (01/04/2016 to 31/03/2017) (QOF)	77.1%	83.5%	79.5%	Comparable with other practices
QOF Exceptions 206/17	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	16.8% (170)	18.2%	12.4%	
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 (01/04/2017 to 31/03/2018) (QOF)	82.6%	84.1%	78.8%	No statistical variation
Exception rate (number of exceptions). (01/04/2017 to 31/03/2018)	20.6% (220)	20.4%	13.2%	N/A

Indicator	Practice performance	CCG average	England average	England comparison
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 (01/04/2016 to 31/03/2017) (QOF)	71.8%	79.6%	78.1%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	7.4% (75)	12.3%	9.3%	
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 (01/04/2017 to 31/03/2018) (QOF)	73.8%	79.1%	77.7%	No statistical variation
Exception rate (number of exceptions). (01/04/2017 to 31/03/2018)	6.9% (74)	14.1%	9.8%	N/A

Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2016 to 31/03/2017) (QOF)	75.8%	82.7%	80.1%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	

	14.4% (146)	17.6%	13.3%	
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 (01/04/2017 to 31/03/2018) (QOF)	78.0%	82.1%	80.1%	No statistical variation
Exception rate (number of exceptions). (01/04/2017 to 31/03/2018)	15.0% (161)	18.2%	13.5%	N/A

Further information
The contractor has monthly multidisciplinary case review meetings where all patients on the palliative care register are discussed.

Other long-term conditions				
Indicator	**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 (01/04/2016 to 31/03/2017) (QOF)	75.8%	78.1%	76.4%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	4.5% (62)	9.8%	7.7%	
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 (01/04/2017 to 31/03/2018) (QOF)	82.8%	76.0%	76.0%	No statistical variation
Exception rate (number of exceptions). (01/04/2017 to 31/03/2018)	14.1% (216)	9.3%	7.7%	N/A

Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
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 (01/04/2016 to 31/03/2017) (QOF)	90.4%	92.7%	90.4%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	22.1% (89)	13.9%	11.4%	

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 (01/04/2017 to 31/03/2018) (QOF)	92.3%	91.3%	89.7%	No statistical variation
Exception rate (number of exceptions). (01/04/2017 to 31/03/2018)	21.8% (94)	14.1%	11.5%	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 (01/04/2016 to 31/03/2017) (QOF)	80.3%	83.9%	83.4%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	2.7% (69)	4.6%	4.0%	
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	82.7%	82.9%	82.6%	No statistical variation
Exception rate (number of exceptions). (01/04/2017 to 31/03/2018)	7.3% (25)	6.9%	6.7%	N/A

Further information
Following the inspection, the practice raised concerns about the accuracy of the Hypertension QOF data we reported. They are currently reviewing their concerns in order to address any inaccuracies with the relevant organisations.

Indicator	Practice	CCG average	England average	England comparison
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 (01/04/2016 to 31/03/2017) (QOF)	89.3%	90.5%	88.4%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	5.8% (18)	8.3%	8.2%	
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 (01/04/2017 to 31/03/2018) (QOF)	92.8%	91.9%	90.0%	No statistical variation
Exception rate (number of exceptions). (01/04/2017 to 31/03/2018)	7.3% (25)	6.9%	6.7%	N/A

Families, Children and Young People — Population group rating: Good

Child Immunisation				
Indicator	**Numerator**	**Denominator**	**Practice %**	**Comparison to WHO target**
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2016 to 31/03/2017)(NHS England)	185	196	94.4%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2016 to 31/03/2017) (NHS England)	205	227	90.3%	Met 90% minimum (no variation)
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) (01/04/2016 to 31/03/2017) (NHS England)	200	227	88.1%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2016 to 31/03/2017) (NHS England)	206	227	90.7%	Met 90% minimum (no variation)
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018)(NHS England)	243	256	94.9%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	188	207	90.8%	Met 90% minimum (no variation)
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) (01/04/2017 to 31/03/2018) (NHS England)	188	207	90.8%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	191	207	92.3%	Met 90% minimum (no variation)

Additional information:

At the time of our inspection the data available to us was for the year 01/04/2016 to 31/03/2017. This showed that of the four areas of childhood immunisation uptake rates, one area, did not meet the target percentage of 90% or above. Following our inspection, the practice told us that as part of their organisational restructure the practice had centralised all administration activities, which previously had been undertaken by many members of staff and this had resulted in improvements to the take up of the vaccinations. Also following our inspection, the data for the period 01/04/2017 to 31/03/2018 became available, which showed the practice had met the 90% uptake rate in all four areas measured.

Working age people (Including those recently retired and students)

Population group rating: Good

Cancer Indicators				
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2016 to 31/03/2017) (Public Health England)	72.8%	75.9%	72.1%	Comparable with other practices
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) **(PHE)**	71.3%	76.3%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)**(PHE)**	63.4%	62.9%	54.6%	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. **(PHE)**	80.0%	66.0%	71.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE)	54.5%	46.5%	51.6%	Comparable with other practices

Additional information:

The practice uptake for cervical screening was below the 80% coverage target for the national screening programme. We discussed this with the practice who told us they were working to improve their uptake rate. We saw evidence that:

- All sample-takers had received appropriate training.
- All sample-takers monitored results from the samples they take including their inadequate rate.
- Women were offered appointments at different times throughout the week.
- A female sample-taker was available.

Following the inspection, the practice advised us of additional actions they are taking to improve the uptake of cervical screening. We have been unable to verify the evidence of this submission as no

further information to demonstrate these actions was received.

- The practice had re-organised its structure to provide a dedicated administrative team, which it anticipated would help improve their rates.
- They write to patients twice and on the third occasion contacts them by telephone.
- Reminders are placed on individual records to encourage opportunistic screening.

People experiencing poor mental health (including people with dementia)

Population group rating: Outstanding

Mental Health Indicators				
Indicator	**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 (01/04/2016 to 31/03/2017) (QOF)	92.3%	94.0%	90.3%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	5.6% (13)	15.1%	12.5%	
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 (01/04/2017 to 31/03/2018) (QOF)	92.0%	93.4%	89.5%	No statistical variation
Exception rate (number of exceptions). (01/04/2017 to 31/03/2018)	3.5% (9)	13.2%	12.7%	N/A

Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	92.7%	93.3%	90.7%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	6.4% (15)	14.2%	10.3%	
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	93.6%	93.3%	90.0%	No statistical variation
Exception rate (number of exceptions). (01/04/2017 to 31/03/2018)	4.2% (11)	13.0%	10.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	80.5%	87.2%	83.7%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	10.4% (19)	8.6%	6.8%	
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	92.6%	87.5%	83.0%	No statistical variation
Exception rate (number of exceptions). (01/04/2017 to 31/03/2018)	6.9% (13)	8.4%	6.6%	N/A

Monitoring care and treatment

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	547	553	539
Overall QOF exception reporting (all domains)	6.4%	6.2%	5.7%

Additional information

We noted that the practice COPD exception rate for the period 01/04/2016 to 31/03/2017 was 22% compared to the CCG average of 14% and national average of 11%. More recent data, not available at the time of our inspection, for the same period in 2017/18 showed no improvement. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.

We discussed this with the practice who were aware of the data and told us they were taking action to reduce their exception rates. Following our inspection, the practice gave us further details. They told us the main reason for their exception reporting was patients not wanting to make an appointment after three invitations to make an appointment and the practice has a strategy for changing this which included:

1. The asthma/COPD specialist nurse was running appointments as part of the extended access service on Saturdays to see if some patients would prefer their reviews on a Saturday
2. The group consultations being trialled for diabetes would be expanded to include asthma and COPD to see if there is a greater uptake.
3. The data lead will be validating the quality of data in outlying areas.
4. The practice meets quarterly with the diabetic consultant and their specialist nurses to review complex diabetic patients and identify appropriate care packages.

We have been unable to verify the evidence of this submission as no further information to demonstrate these actions was received.

Coordinating care and treatment

Indicator	Y/N
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2016 to 31/03/2017) (QOF)	Yes

Helping patients to live healthier lives

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 (01/04/2016 to 31/03/2017) (QOF)	94.8%	95.6%	95.3%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	0.8% (36)	0.8%	0.8%	
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 (01/04/2017 to 31/03/2018) (QOF)	94.9%	95.1%	95.1%	No statistical variation
Exception rate (number of exceptions). (01/04/2017 to 31/03/2018)	0.5% (23)	0.9%	0.8%	N/A

Effective staffing

Question	Y/N
The learning and development needs of staff were assessed	Yes
The provider had a programme of learning and development.	Yes

Additional information:

The practice understood the learning needs of staff and provided protected time and training to meet them. Staff were encouraged and given opportunities to develop. The practice supported apprenticeship training, with staff having completed Level 3 Clinical Health Care Support apprenticeships. Other staff were undertaking nurse associate apprenticeships, degree apprenticeships. In addition, nurses had been trained as prescribers and nurses had received specialist training in long term conditions. This additional information was provided by practice following the inspection and remains unverified.

In the last six months, the practice had commenced with re-organising their staffing structure and roles.

A recent audit of the new arrangements had shown they were not adequately tracking staff training. One aspect of this was the practice had identified an improved electronic training log was required. At the time of inspection, the practice was in the process of transferring paper refresher systems onto the electronic log and scanning certificates against the log. The electronic log showed some staff had not completed infection control training. A plan of action had been written to address this, but was not yet completed.

However, following the inspection, the practice provided further evidence which showed that all staff, other than those on long term leave, had completed this training. They told us the evidence we saw on the day of our inspection had not been updated with the latest information.

On the day of our inspection the practice did not have a lead nurse and were in the process of recruiting a person for this role. Staff we spoke to expressed concern at not having a lead nurse. Some said they found it difficult to discuss or report issues to the management team due to them having full diaries. The practice told us they had faced challenges in filling the role of lead nurse and were in the process of recruiting a person for this post. In response to staff concerns that senior managers were not available to discuss issues, a personal assistant to the practice manager had been recruited and had been in post five months at the time of the inspection. The aim of this post was to improve access to the manager's diaries. The nursing team have also been given mentorship training by Health Education England to support other colleagues.

Following the inspection, the practice provided evidence that a lead nurse had been appointed in December 2018.

Caring

Kindness, respect and compassion

CQC comments cards	
Total comments cards received	16
Number of CQC comments received which were positive about the service	14
Number of comments cards received which were mixed about the service	2
Number of CQC comments received which were negative about the service	Nil

Examples of feedback received:

Source	Feedback
Comments cards.	Prior to our inspection we sent the practice some blank CQC comment cards and asked the practice to put them in the waiting area for patients to complete. We received 16 comment cards. Two were mixed in their comments, saying sometimes it was hard to get an appointment. Most of the cards were highly complementary of the service using words such as outstanding, highly professional, first class and excellent.
Patients	During our inspection we spoke with three patients about their experience of the service. They all told us they were happy with the service provided. They said appointments were easy to get, staff were friendly and professional. They told us Clinical staff gave them enough time and discussed treatment options with them so they could make informed choices about their care.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology has changed in 2018. This means that we cannot be sure whether the change in scores was due to the change in methodology, or was due to a genuine change in patient experience.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
22643	255	118	46.3%	0.52%

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	88.7%	91.8%	89.0%	Comparable with other

Indicator	Practice	CCG average	England average	England comparison
healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)				practices
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 (01/01/2018 to 31/03/2018)	88.4%	90.5%	87.4%	Comparable with other practices
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 (01/01/2018 to 31/03/2018)	96.5%	97.4%	95.6%	Comparable with other practices
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	89.2%	87.8%	83.8%	Comparable with other practices

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

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 (01/01/2018 to 31/03/2018)	96.0%	95.9%	93.5%	Comparable with other practices

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

Additional information The practice had signage on doors and at other strategic points that included a braille translation for blind people. Downstairs toilet doors also had signage approved for being dementia friendly.	

Carers	Narrative
Percentage and number of carers identified	The practice had identified 549 of the patients on their list as being carers. This was approximately 2.4% of patients.

Any additional evidence
The practice had been awarded a platinum award for caring for carers by a local charity working in partnership with the local authority. They had won the award for their work with carers because they ensured priority and flexible access to appointments and an annual health check for this group of patients. 342, or 62% of carers had received a health check in the past 12 months. There was close liaison with the local Wiltshire Carers trust to provide support, including benefit advice to all carers within the practice. The practice also offered carers a yearly educational event.

Privacy and dignity

Question	Y/N
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Yes

Question	Y/N
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes

Examples of specific feedback received:

Source	Feedback
Friends and Family test	The practice encouraged patients to complete the friends and family test. This asks patients how likely they are to recommend their GP practice to friends and family if they needed similar care or treatment. In the past 12 months 1,855 patients had completed this survey and 87% said they were likely or highly likely to recommend the practice.

Responsive

Responding to and meeting people's needs

Practice Opening Times	
Day	**Time**
Monday	8am to 8pm
Tuesday	8am to 8pm
Wednesday	8am to 8pm
Thursday	8am to 8pm
Friday	8am to 8pm

Appointments available with GP
Routine face to face appointments with a GP were available from 8.30am to 12.30pm and 2pm to 8.00pm. Triaged calls and telephone appointments are from 8:00am to 6.30pm.
Additional provision
The practice worked in partnership with other local practices to provided additional access to GP appointments on weekday evenings up to 8pm and at weekends.

Home visits	Y/N
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention	Yes
If yes, describe how this was done	
Requests for a home visit were triaged by a clinician.	

Any additional evidence
The practice used social prescribing and social care signposting to support patients. They had a wide range of support groups for patients with needs. For example, there were A Hearing Loss Group that met monthly A Memory Group that met monthly A Brain Injury Group that met monthly A Carers Group that met monthly A DEA drop-in advice service that was arranged ad hoc at various times during the year A Fibromyalgia Group that met monthly A Friends after Bereavement Group that met monthly A Health Trainer drop in sessions that were arranged ad hoc as required A Knitting Group that met twice monthly An MS group that met monthly A British Legion drop in group that met weekly

A Sight Loss Group that met monthly
A Tinnitus Group that met three monthly
A Learning Disability Group that met three monthly
An Advocacy service drop in that met Ad hoc at various times during the year

These groups were advertised on the practice website, in the practice waiting area and on their Facebook and Twitter pages. Anyone could attend these group not only patients registered at the practice. The groups met in the practice café where tea and coffee were provided.

The practice had a signposting team who led this work. These staff would attend groups when they started but the aim was that they would either be self-sufficient or led by an external facilitator. The team also prepared signposting information for nurse led clinics, such as the practice diabetic clinic.

The team did regular surveys of patients attending these groups and acted to improve the service based on this feedback, where appropriate. They collected numbers of people attending these groups and examples and case studies of how individuals had benefited from attending these groups. The evidence showed some groups were usually attended by ten or more patients.

The evidence seen about these groups included promotional material, patient's surveys, annual reviews and goals, case studies and audits of numbers attending. At the strategic level we saw evidence the practice was continuing to consider other groups they could develop. There was a calendar of national campaigns the practice wanted to link with in the future.

The practice hosted a variety of ad hoc events aimed at reaching a wide range of people. Recent events included events on World Diabetes Day and Older Persons Day; and we saw that a veteran's support event was planned.

The practice was a dementia friendly GP practice, with two members of staff trained as dementia trainers to ensure that all new staff are trained as dementia friendly staff. The practice supports other surgeries in the area to become dementia friendly practices, by undertaking surveys and developing action plans and training for staff.

The partners planned and designed a café as part of their vision for how services should be delivered in a new caring manner; they have set up and manage support cafes to provide emotional support and information to those close to people who use services, including carers, family and dependants. A dedicated member of staff links in with other agencies to set up support cafes.

The practice invited in Healthwatch Wiltshire together with a learning disability group to review the practice systems and processes with regard to learning disability and to recommend improvements to the service. This included staff developing Makaton cards for supporting patients.

The practice has a dedicated signposting team who maintain links with advocacy groups and support networks within the voluntary sector and local community. They attend staff meetings and update the team on the groups and how information can be signposted to them. Staff make internal referrals to the team where they consider a patient, carer or family requires additional support but are uncertain how to access the group. The practice provided us with this information following the inspection, which has not been verified.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
22643	255	118	46.3%	0.52%

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 (01/01/2018 to 31/03/2018)	97.8%	95.6%	94.8%	Comparable with other practices

Timely access to the service

National GP Survey results

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 (01/01/2018 to 31/03/2018)	73.6%	77.2%	70.3%	Comparable with other practices
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	70.0%	75.4%	68.6%	Comparable with other practices
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	71.9%	69.8%	65.9%	Comparable with other practices
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	73.8%	81.0%	74.4%	Comparable with other practices

Any additional evidence
The practice had systems in place to monitor the telephone system and how long callers were waiting. This included a large monitor screen in the call handlers room, which on the day of our inspection at approximately 9.30am showed the average wait that day was less than 20 seconds.

Feedback received from patients:

Source	Feedback
For example, NHS Choices	The practice analysed and responded where appropriate, to patient feedback they collected from various sources including: • Complaints • Patients groups • Facebook • Friends and family test • NHS Choices As part of our inspection we looked at the reviews people had left on NHS Choices website (www.nhs.uk/Services/GP). The practice had an average rating of 3.5 out of 5 based on 27 reviews. Of the seven most recent reviews four gave a score of 5 out of 5 and three gave a score of 1 out of 5. The two negative reviews gave concerns about difficulties in getting appointments. We noted that the practice had responded to all the reviews on the NHS Choices website.

Listening and learning from complaints received

Complaints	Y/N
Number of complaints received in the last year.	2017/18 = 103
Number of complaints we examined	April to Nov 2018 = 88
Number of complaints we examined that were satisfactorily handled in a timely way	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman	nil

Additional comments:

The practice told us that in the past 12 months they had re-organised their staff structure, particularly the administration and reception teams. A recent audit of these arrangements had found some issues. For example, they found final letters to complainants did not always include information about how to escalate the complaint to the Ombudsman if they were not satisfied with the practice response, as recommended in recognised guidance. We saw evidence the practice had taken action to ensure future letters were in line with their policy. We noted that information on how to escalate complaints was in the practice complaints information leaflet which was available from the practice and their website.

We noted that the one final complaint letter written since the audit had been completed included the escalation information.

The practice had an open and transparent approach to complaints. Learning points were shared with appropriate staff using a variety of methods. They were initially discussed in staff meeting and learning points were often included in staff newsletters. However, there was no clear system for ensuring all appropriate staff were informed of the learning points, such as those unable to attend meetings. Following the inspection, the practice confirmed that all staff were advised at induction that they need to keep up to date with information and meetings minutes circulated and added to the shared drive. We have been unable to verify evidence to support the additional actions.The practice had done a review of their complaints to look for themes and common issues. We saw evidence they had taken steps to improve their service in a number of areas.

Examples of how quality has improved in response to complaints

1. When a patient complained about difficulties in using the online process for ordering a repeat prescription, the practice reviewed their website and made some changes to make it easier to navigate to the right page.
2. A patient complained that they were given an appointment with a nurse and when they attended the appointment found the nurse did not specialise in the patient's condition and had to make a second appointment. This was a waste of both the nurse's and patient's time. Following the complaint, the practice drew up a complete list of the areas of specialism for all clinical staff and the time required for specific appointments, which was shared with reception staff and the call centre staff to help them ensure they gave patients appointments with the right clinician. We saw evidence the practice kept this list updated.
3. In response to a number of complaints regarding the appointment system the practice made a number of changes to their appointment system. This included having one centralised team to manage the appointments in the main surgery and the three branch surgeries and having on-the-day appointments available at branch surgeries. We saw evidence the practice actively monitored elements of their appointment system, such as how long patients waited

Well-led

Leaders had the capacity and skills to deliver high quality sustainable care

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes (see below)
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes (see below)
There was a leadership development programme in place, including a succession plan.	Yes (see below)

Explanation of any answers and additional evidence:

The partners meet once a quarter to form and monitor actions against the strategic plan of the practice. The partners had undertaken a skills matrix assessment to identify areas where additional support and training was required in relation to their management responsibilities.

Following our inspection, the practice told us;

- The nursing team being given additional training and support to become middle leaders in speciality areas, encouraging them to lead areas across several practices.
- The practice was taking part in the national Trainee Nurse Associate pilots phase 2 and 3 so they can support and retain own HCAs and train them as nurses within the practice.
- The nursing team being given additional training and support to become middle leaders in speciality areas, encouraging them to lead areas across several practices; leg ulcers, diabetes, elderly care. Planning also taking place within the team to replace those who are likely to retire and planning and support to encourage some to become the nurse leads of the future.
- Some HCAs and middle managers were undertaking degree apprenticeships
- The delegation of traditional Practice Manager role tasks were shared within the speciality areas; HR, Finance, IT to ensure shared learning and development opportunities.

We have been unable to verify the evidence of this submission as no further information to demonstrate these actions was received."

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy in place to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes

Explanation of any answers and additional evidence:

The practice discussed all aspects of practice development with the PPG and liaised with the CCG regularly.

We saw evidence the practice had been involved in the development of new and innovative services, in line with their vision to provide high quality sustainable care. Staff within the practice initiated, developed and led on collaborative schemes to increase resilience within the practice. This included:

- A salaried GP and a nurse run an elderly care scheme to ensure high quality care was provided to these patients by the practice and care home staff.
- A lead diabetic nurse ran group consultations for patients with diabetes; insulin initiation, keeping on track with diabetes and diabetes in care homes.
- The lead Leg Ulcer nurse ran social model leg ulcer scheme, using a multi-disciplinary team from the practice.

The practice held annual away days, undertakes staff surveys and gathers information from staff monthly meetings. Following our inspection, the practice told us this information was used to feed into their strategic and operational planning.

We have been unable to verify the evidence of this submission as no further information to demonstrate these actions was received.

Culture

The practice had a culture of high quality sustainable care

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
The practice's speaking up policies were in line with the NHSI National Raising Issues Policy.	Yes

In the last six months and as part of the practice strategic plan, the practice started the roll out of the re-organised staffing structure containing new roles and responsibilities designed to improved quality and standards.

This was a significant change within the practice and included all the clinical, administration and reception teams. It had resulted in the formation of specialist teams; the development of middle managers and team leads. At the time of the inspection, the roll out was on-going whilst new staff are recruited and terms and conditions for new posts were being agreed.

The priority areas for the roll out of the organisational restructure were leadership of the programme through the formation of partner/SLT working groups, middle managers, audits to prioritise key areas and monitoring of the roll out through a Dashboard reporting system to the partners working groups.

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

Source	Feedback
Questionaire	As part of our inspection we distributed staff questionnaires to practice staff and received back 20 completed form. Staff said, the practice was a friendly and supportive working environment, management was supportive and approachable, staff views were listened to.
Interviews with staff	Staff we spoke with during the inspection told us they were happy with their work and the practice had an open supportive culture.

Governance arrangements

Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.	
Practice specific policies	We found the practice had a full range of policies covering areas such as safeguarding and communications. We found the policies we saw to be clear and were regularly reviewed.

	Y/N
Staff were able to describe the governance arrangements	Yes
Staff were clear on their roles and responsibilities	Yes

Any additional evidence
The practice told us as part of the practice strategic vision and how they started the roll out of the re-organised staffing structure containing new roles and responsibilities designed to improved quality and standards. This was a significant change within the practice which resulted in the formation of a number of specialist teams. For example, they had created a dedicated HR team, and introduced a new team of middle managers and team leaders where previously there had been none. The partners had also formed three sub groups to lead on key issues. There was a staff working group, a finance working group and a quality and standards working group. These groups meet once a quarter. The priority areas for the roll out of the organisational restructure were leadership of the programme through the formation of partner/SLT working groups, middle managers, audits to prioritise key areas and monitoring of the roll out through a Dashboard reporting system to the partners working groups. Five partners and the two senior managers formed a staff working group to lead the organisational changes, roll out the organisational structure, manage staffing queries and feed-back to other partners. Audits were undertaken as the organisational structure was rolled out to identify gaps in the service; improvement plans were put in place to increase the quality and standards of service. On the day of inspection examples of these were seen in the HR team, which included improved staff recruitment processes, improved induction processes as a result of feedback from exit interviews and training systems. During the inspection we identified the recording and monitoring of training required further improvement. The practice was aware of this and provided additional evidence to show all staff were up to date with mandatory training.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems in place which were regularly reviewed and improved.	Yes
There were processes in place to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

Major incident planning	Y/N
Major incident plan in place	Yes
Staff trained in preparation for major incident	Yes

Any additional evidence
In response to patient feedback about difficulties in making an appointment, the practice had reviewed and amended their appointment system. These changes which had been discussed and approved by the practice Patients Participation Group, included; • The reorganisation of the administration and reception teams to create a specialist call handling team. • Creation of a centralised appointment system that covered the main practice and their three branch surgeries. • A centralised duty team to triage appointment requests • An increase in the number of on-the-day appointments available. • Pro-active monitoring of call waiting times. Following our inspection, the practice told us they also used appointments within the extended access provision to address low uptake in certain QOF areas and to reduce need for exception reporting (the majority of which are due to patients who 'did not attend' three contacts requesting them to make an appointment). We have been unable to verify the evidence of this submission as no further information to demonstrate these actions was received. We saw evidence the practice had recently reviewed their new system and had made a number of changes to further improve the system. This included updating their phone system. We noted that the three patients we spoke to on the day of our inspection told us their appointments had been easy to arrange and they had not had to wait a long time to get through to the practice when they phoned.

Appropriate and accurate information

Question	Y/N
Staff whose responsibilities include making statutory notifications understood what this entails.	Yes

Any additional evidence
We noted that reports, such as audits and were clear

Engagement with patients, the public, staff and external partners

Feedback from Patient Participation Group;

Feedback
The practice had an active Patients Participation Group (PPG) At the PPG's request, the practice had set up a registered charity called, The Friends of Salisbury Medical Practice, which was separate from the PPG and which aimed to raise funds to support practice activities not funded by the NHS. For example, the practice had raised funds to offer dementia friendly Tai Chi sessions. Patients of the practice who previously raised concerns were encouraged to join the PPG as critical friends. We saw examples of two patients who had joined the PPG to provide feedback and support improvements.

Any additional evidence

We looked at feedback on NHS Choices. (https://www.nhs.uk/Services/GP/ReviewsAndRatings)

The practice average score was three stars, out of a possible maximum of five. There had been 16 feedback rating posted in the past 12 months. The main elements praised by reviewers was the quality of care they received and the professionalism of the clinical staff. The key area of concern mentioned by reviewers were difficulties in getting appointments. We noted that the practice had responded to all the reviews and in some cases suggested the patient make a formal complaint so the practice could get further information so they could investigate in more detail.

The practice had a communication and engagement lead to support engagement with patients, public, staff and external partners. This engagement work covered a wide range of areas. For example;

- The practice ran staff events to support local charities,
- The practice was part of the Safer and Supportive Salisbury group, Salisbury Health and Wellbeing group and Dementia Action Alliance.

The practice collected complimentary comments from patients so they could be shared with staff. Comments were shared with staff by their internal email system.

The practice undertook anonymous staff surveys and exit interviews with staff when they left the practice to help them get a better understanding of the views of staff. The practice also confirmed how they engaged with local GP alliance groups and the CCG on various working groups to support development of improved and innovative services.

We have been unable to verify the evidence of this submission as no further information to demonstrate these actions was received.

Continuous improvement and innovation

Examples of improvements demonstrated as a result of clinical audits in past two years

Audit area	Improvement
Audit of patients not identified as being diabetic with a blood sugar level over a standard level to ensure adequate follow up has been carried out.	The audit had identified that due to incorrect coding approximately 2% of patients meeting the audit criteria had not been adequately followed up. The practice took steps to ensure these patients identified were seen by a clinician and ensure that clinical staff knew how to enter the correct codes.

Any additional evidence
The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Following the inspection, the practice provided us with evidence of additional continuous improvement activity. However, we have not been able to verify the activity or the impact of improvements. Services were regularly reviewed and monitored to ensure the objectives and outcomes were being met. Examples of this included internal improvements and how the practice contributed, joined and supported external improvements to health and care services. • Reviews and changes to the appointment system to ensure patients were seen by the appropriate person at the right time • Employing a data lead as part of the organisational restructure who interrogates the clinical system to identify areas that can be improved; providing the GPs with relevant data to make informed decisions and changes. • The long-term condition group consultation project encouraged and enabled peer support of long term condition management, removed variation in care between practices by sharing best practice and encourages shared use of experienced nurses. • The practice was part of a quality and standards working group of GPs and managers to review data and improve systems such as reducing DNA rates. The practice had a clear plan for conducting clinical and non-clinical audits. Some audits, such as minor operation audits were done monthly, some such as a staff records audit were done quarterly and some such as an audit of EpiPen and betablocker co-prescribing were done annually. We saw evidence of over four full cycle clinical audits. (Full cycle audits are those that have been repeated to monitor improvements made.) We noted that the audit reports we saw were clearly laid out, with information covering, why the audit was being done, how it was done, the findings, action taken and when the audit would be repeated. The practice was accredited as a research practice with Wessex Clinical Research Network, which is part of the National Institute for Health Research. GPs and nurses participated in the research and had been trained for this role. The practice also participated in national and local initiatives to improve health and social care services in the local area. This included the pilot, roll- out and support to other practices for the Red bag initiative; ‘dip or not to dip’ and the elderly care scheme. The practice shared how undertaking acute and planned visits meant the number of people who might otherwise have attended hospital were significantly reduced. This information was provided by the practice following the inspection and has not been verified.

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 comparable, 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 comparable 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 Band	Z-score threshold
1	Significant variation (positive)	Z ≤-3
2	Variation (positive)	-3 < Z ≤ -2
3	Comparable to other practices	-2 < Z < 2
4	Variation (negative)	2 ≤ Z < 3
5	Significant variation (negative)	Z ≥3
6	No data	Null

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.

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: http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease
- **PHE**: Public Health England
- **QOF**: Quality and Outcomes Framework (see https://qof.digital.nhs.uk/).
- **RCP**: Royal College of Physicians.
- **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.(See NHS Choices for more details).