Care Quality Commission

Inspection Evidence Table

The Gillies and Overbridge Medical Partnership (1-540234371)

Inspection date: 20 March 2019

Inspection date: 21 March 2019

Date of data download: 13 March 2019

Overall rating: Requires Improvement

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe Rating: Requires Improvement

Safety systems and processes

The practice did not always have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Partial
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Partial
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y

Safeguarding	Y/N/Partial
Explanation of any answers and additional evidence: The practice was unable to evidence that staff had received safeguarding training in line with practice policy. We reviewed staff training records and found that there was no record that six members of the 126 staff had completed safeguarding children training and no record that four members of staff had completed safeguarding adults training. The practice's safeguarding policy had not been updated to reflect national guidelines regarding the level of training required by staff. For example, it identified that nursing staff should be trained to safeguarding children level 2. However, the practice confirmed that all GPs and Nurses were trained to safeguarding children level 3 in line with recent guidance.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff had any necessary medical indemnity insurance.	Y
Explanation of any answers and additional evidence: We reviewed recruitment records and found that the practice was not consistently following their recruitment policy with regard to obtaining references. For example, we reviewed five staff files and found that three were missing pre-employment references. We discussed this with the practice on inspection. They advised that verbal references were obtained for two of the employees, but this had not been documented in staff files. Following the inspection, the practice sent us confirmation that the references had been retrospectively recorded.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: Gillies Health Centre March 2019 St Andrews May 2018 Essex House September 2018	Y
There was a record of equipment calibration. Date of last calibration: Gillies Health Centre July 2018 St Andrews June 2018 Essex House October 2018	Y
There were risk assessments for any storage of hazardous substances for example, liquid	n/a

nitrogen, storage of chemicals.	
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: Gillies Health Centre March 2019 St Andrews March 2019 Essex House September 2018	Y
There was a log of fire drills. Date of last drill: Gillies Health Centre February 2019 St Andrews March 2019 Essex House May 2018	Y
There was a record of fire alarm checks. Date of last check: Gillies Health Centre March 2019 St Andrews March 2019 Essex House March 2019	Y
There was a record of fire training for staff.	Partial
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: Gillies Health Centre March 2013 St Andrews February 2019 Essex House 2016	Partial
Actions from fire risk assessment were identified and completed.	Partial

Explanation of any answers and additional evidence:

Processes to ensure fire safety were not embedded. For example;

- The practice could not evidence that up to date fire risk assessments had been carried out for the main site or for Essex House. The risk assessment which had been completed for the main site was dated March 2013 and there was no evidence that the risk assessment had been reviewed.
- Items identified as requiring action on the risk assessment for Essex House had not all been completed. For example, it was identified that the practice needed to certify their fixed wire testing. This had not been completed. However, the practice confirmed that an engineer had been booked into undertake this work for 23 and 24 March 2019.
- A risk assessment had been conducted for the St Andrews site, this had been conducted by the site manager, but the practice was not aware of this.
- On inspection the practice was unable to evidence that a fire drill had been conducted at the Essex House site in line with their risk assessment. We discussed this with staff at the Essex House site, who were unclear if one had been carried out. Following inspection, the practice sent us confirmation that a drill had been conducted in May 2018.

- We reviewed staff training records and found that not all staff had received fire training in line with practice policy.

Health and safety		Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: Gillies Health Centre St Andrews Essex House	 May 2018 February 2018 22 March 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Gillies Health Centre St Andrews Essex House	 May 2018 February 2018 March 2017	N

Explanation of any answers and additional evidence:

The practice's health and safety policy had not been updated since the practice merged in 2018. The policy that was used and referred to was dated September 2014.

The practice did not have consistent oversight of premises/security risk assessments. On inspection we saw that a risk assessment had been completed for the St Andrews site by the site manager. However, the practice was unable to evidence that one had been conducted for the main site and for Essex House. Following inspection, the practice sent us evidence to show that a premises risk assessment had been conducted for the Gillies Health Centre dated May 2018. They also sent us a premises risk assessment for Essex House dated 22 March 2019.

We reviewed the health and safety risk assessment conducted for the Essex House site and found that not all items identified as requiring action had been completed within the specified time frame. For example, the risk assessment had identified that periodic testing and treatment of cold water storage tanks should be conducted or that periodic tests should be carried out. The agreed timescale for this action to be completed was six weeks following the risk assessment. On inspection, there was no evidence that historic monitoring of water temperatures had been conducted. A water sample had been taken on 20 March 2019 but there was no evidence that this had been conducted prior to inspection.

We reviewed the health and safety risk assessment conducted for the main site and found that information was not always accurate. For example, the risk assessment identified that all staff were up to date with their infection control training, however our inspection identified that this was not correct as we found that 11 members of staff had not completed this training.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not always met.

	Y/N/Partial
There was an infection risk assessment and policy.	Partial
Staff had received effective training on infection prevention and control.	N
Date of last infection prevention and control audit:	February

	2019
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

Infection prevention and control (IPC) risk assessments had been conducted for each location. However, we found that these were not always complete and did not always accurately reflect possible concerns. For example, the risk assessments conducted for the Gilles Health Centre and for the St Andrews site identified that there was a legionella risk assessment and risk management plan available. However, our inspection identified that while a risk assessment for legionella had been carried out, there was no record of action taken as a result and the practice did not have effective legionella monitoring. The risk assessment for the Essex House site had not been completed. There were no records for 15 areas of the risk assessment to determine what action was required.

We reviewed staff training records and found that 11 members of staff had not completed IPC training including one advanced nurse practitioner and two GPs.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety but these were not always effective

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Partial
Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

Explanation of any answers and additional evidence:

The practice did not always have an effective system to manage staff absences and busy periods. Feedback from staff during inspection included that there was not adequate cover for holiday and sickness. The practice advised us that there were several staff vacancies and that they were in the process of trying to recruit new staff.

The practice's arrangements to mitigate risk relating to Legionella infection was not effective. Legionella risk assessments had been conducted for the main site and for the St Andrews site however areas identified as requiring action were not completed. These included the monitoring and recording of water temperatures. The practice advised that the cleaners at the main site the Gillies Health Centre, regularly flushed the system but they were unable to evidence this. Following inspection, the practice sent us confirmation that this had been conducted and we reviewed evidence which showed that the cleaning company carried out weekly flushes of the shower system.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHS Business Service Authority - NHSBSA)	0.94	0.84	0.94	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected	6.4%	7.4%	8.7%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) (NHSBSA)				
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2018 to 30/09/2018) (NHSBSA)	5.07	5.13	5.64	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2018 to 30/09/2018) (NHSBSA)	3.88	2.59	2.22	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Partial
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels	Y

Medicines management	Y/N/Partial
and expiry dates.	
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:

We found that the practice's process to ensure medicines were stored securely was not consistent across the three sites. For example, at the St Andrews site we found the room which held the emergency medicines and medical equipment was unlocked. This meant the practice could not be assured that access was limited to authorised personnel.

The practice's system to ensure staff had the appropriate authorisations to administer medicines was not embedded. We reviewed the practice's patient group directions (PGDs) and found that not all required staff who had administered the flu vaccine had signed the necessary PGD for 2018/2019. We raised this with the practice who issued a new PGD to be signed by the staff member. Following the inspection, the provider sent us evidence to show that a significant event had been raised as a result.

The practice did not have a specific process or protocol for the monitoring of patients taking high risk medicines. We reviewed records of patients taking high risk medicines and found that they had not all received the appropriate monitoring. For example, we saw that one patient prescribed Lithium had not received a blood test since 2017 but had continued to receive their repeat prescription which was last issued in March 2019. Following inspection, the practice sent us confirmation that a new protocol had been implemented to ensure high risk medicines were monitored effectively.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded since July 2018:	59
Number of events that required action:	30

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

Event	Specific action taken
A significant event was raised when a home visit wasn't conducted. It was identified that it had been assigned after	The significant event was discussed at a meeting and a change of process was implemented. This included ensuring all home visits would be allocated to GPs before 12pm and GPs would

the GP had left to conduct the visits on their list	be notified of this through the IT system. If other home visits were required after this point and before 1pm then the GPs would be contacted directly. All other home visits would be allocated within the duty team.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence: The practice did not have proper oversight of Medicines and Healthcare products Regulatory Agency (MHRA) alerts. We found that their process to act on alerts received was not effective in practice. A repeat medicine alert affecting patients of childbearing age taking sodium valproate was issued to GP practices in December 2018. When the alert was received, an initial audit was conducted in January 2019 and GPs were tasked to contact their patients affected. A repeat audit was scheduled for April 2019. On inspection we conducted a search to review the action taken following the initial audit in December 2018. We identified that 28 patients prescribed the medicine who were of childbearing age had not been in contact with the practice. We reviewed the records of 12 of those patients and found that further action was still required for five of those patients. We raised this with the practice who told that they would be issuing a letter to the patients to urge them to get in contact.	

Effective Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
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 were in place 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
Explanation of any answers and additional evidence: The practice employed a community matron who worked with the practice's frail and elderly population.	

A referral would be made to the matron from a clinician in the practice and the patient would receive a frailty review and advanced care plan. The matron accessed services, including social prescribing to signpost patients to services available to them and was also able to conduct long-term condition reviews in patients' homes if they were unable to attend the practice.

The matron also took part in a clinical commissioning group (CCG) funded pilot which included conducting ward rounds at the two nursing homes registered with the practice. They would visit the nursing homes once a week and would discuss two patients in detail followed by any acute concerns. The practice told us that this intervention had reduced the number of emergency call outs they received from the nursing homes but were unable to provide data to support this.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHSBSA)	1.28	0.82	0.81	No statistical variation

Older people — Population group rating: Good

Findings

- The practice employed a community matron who was able to conduct a full assessment for patients identified as living with moderate or severe frailty. This would include 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.
- 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.

People with long-term conditions — Population group rating: Good

Findings

- Patients with long-term conditions had 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.
- The practice held monthly diabetic multidisciplinary team meetings to discuss complex patients.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- 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.

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 (01/04/2017 to 31/03/2018) (QOF)	80.3%	77.2%	78.8%	No statistical variation
Exception rate (number of exceptions).	32.0% (331)	17.0%	13.2%	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 (01/04/2017 to 31/03/2018) (QOF)	67.5%	74.9%	77.7%	No statistical variation
Exception rate (number of exceptions).	34.8% (359)	14.7%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	89.2%	79.5%	80.1%	Variation (positive)
Exception rate (number of exceptions).	27.4% (283)	15.4%	13.5%	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 (01/04/2017 to 31/03/2018) (QOF)	88.9%	76.9%	76.0%	Variation (positive)
Exception rate (number of exceptions).	50.2% (611)	11.0%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	93.5%	89.9%	89.7%	No statistical variation

Exception rate (number of exceptions).	37.4% (110)	12.0%	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 (01/04/2017 to 31/03/2018) (QOF)	79.8%	81.4%	82.6%	No statistical variation
Exception rate (number of exceptions).	9.9% (257)	5.4%	4.2%	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 (01/04/2017 to 31/03/2018) (QOF)	96.2%	89.1%	90.0%	No statistical variation
Exception rate (number of exceptions).	6.2% (12)	6.1%	6.7%	N/A

Any additional evidence or comments

The above QOF figures relate to 2017/2018 and refer only to The Gillies and Overbridge Health Centre before the practice merged in July 2018.
We discussed the historic high exception reporting for The Gillies and Overbridge Health Centre with the practice and reviewed unverified figures for the 2018/2019 QOF year.
The figures we reviewed relate to 1 April 2018 to 20 March 2019. We found that:

- The overall exception reporting for diabetes related indicators was 9%
- The overall exception reporting for asthma related indicators was 9%.
- The overall exception reporting for COPD related indicators was 22%.

Families, children and young people Population group rating: Good

Findings

- 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.
- 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.
- Young people could access services for sexual health and contraception.

Child Immunisation	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) (01/04/2017 to 31/03/2018) (NHS England)	181	195	92.8%	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)	186	213	87.3%	Below 90% minimum (variation negative)
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)	183	213	85.9%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	185	213	86.9%	Below 90% minimum (variation negative)

Any additional evidence or comments

The above QOF figures relate to 2017/2018 and refer only to The Gillies and Overbridge Health Centre before the practice merged in July 2018.
We discussed the historic achievement for child immunisations by The Gillies and Overbridge Health Centre prior to the merger and the practice provided unverified data for the 2018/2019 QOF year. The figures provided, which at the time of inspection had not been externally verified, showed that the practice had consistently met the 90% national target.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- 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 medicines without the need to attend the practice.
- As part of their improved access, the practice offered pre-bookable appointments from 6.30pm to 8.00pm Monday to Friday and 8.00am to 11.00am on Saturday mornings.
- Cervical screening uptake figures were below national targets.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	67.6%	73.5%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	72.7%	73.6%	70.0%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	58.5%	60.9%	54.5%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	75.9%	70.0%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	48.1%	54.0%	51.9%	No statistical variation

Any additional evidence or comments
The above figures relate to 2017/2018 and refer only to The Gillies and Overbridge before the practice merged in July 2018. We discussed the historic uptake of cervical smears achieved by The Gillies and Overbridge with the practice on inspection, they were aware that their uptake figures were lower than national targets and had introduced evening and weekend appointments to try and improve this. Following inspection we reviewed unverified data for the 2018/2019 QOF year which showed cervical smear uptake levels were above the national target.

People whose circumstances make them vulnerable

Population group rating: Good

Findings
• 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 held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. • The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health

Population group rating: Good

(including people with dementia)

Findings
• The practice offered patients experiencing poor mental health double appointments if required. • 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.

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 (01/04/2017 to 31/03/2018) (QOF)	100.0%	91.7%	89.5%	Variation (positive)
Exception rate (number of exceptions).	50.5% (54)	14.2%	12.7%	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 (01/04/2017 to 31/03/2018) (QOF)	100.0%	88.1%	90.0%	Variation (positive)
Exception rate (number of exceptions).	49.5% (53)	12.6%	10.5%	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 (01/04/2017 to 31/03/2018) (QOF)	91.1%	82.5%	83.0%	No statistical variation
Exception rate (number of exceptions).	36.4% (32)	7.6%	6.6%	N/A

Any additional evidence or comments
The above QOF figures relate to 2017/2018 and refer only to The Gillies and Overbridge Health Centre before the practice merged in July 2018. We discussed the historic high exception reporting for The Gillies and Overbridge Health Centre prior to the merger with the practice and reviewed unverified figures for the 2018/2019 QOF year. The figures we reviewed relate to 1 April 2018 to 20 March 2019 and had not been externally verified. We found that the overall exception reporting for mental health indicators was 8%.

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)	551.4	544.1	537.5
Overall QOF exception reporting (all domains)	15.4%	6.3%	5.8%

	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

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

The practice conducted an audit which looked at patients prescribed a combination of opioid medicines for long term pain management (opioids are a class of pain relieving medicines). It was identified that for those prescribed these medicines, there was a high risk to their health and there was little evidence that opioid medicines were more effective than non-opioid medicines.
A search was conducted on patients who were prescribed a specific combination of two opiates. The practice identified 115 patients on these two medicines. Each GP was given a list of their patients to review. A repeat audit was conducted five months later. The repeat audit identified 29 patients prescribed the medicines. The practice had reduced the number of patients on these medicines by 75%.

Effective staffing

The practice was unable 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.	Partial
The learning and development needs of staff were assessed.	Partial
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.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician	Y

associates.	
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: The practice did not have effective oversight of staff training and therefore could not be assured that staff had the necessary skills and knowledge. We reviewed the log of training considered necessary as determined by the practice and we found that not all staff had completed basic life support or fire safety training. We found that not all staff had received an appraisal. On inspection we saw confirmation that appraisals which were overdue had been scheduled.	

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 (01/04/2017 to 31/03/2018) (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

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
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 (01/04/2017 to 31/03/2018) (QOF)	90.9%	93.7%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.4% (19)	0.8%	0.8%	N/A

Any additional evidence or comments
The above results relate specifically to The Gillies and Overbridge practice prior to the practice merger in July 2018.

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

Caring

Rating: Good

Kindness, respect and compassion

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

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

CQC comments cards	
Total comments cards received.	19
Number of CQC comments received which were positive about the service.	7
Number of comments cards received which were mixed about the service.	5
Number of CQC comments received which were negative about the service.	7

Source	Feedback
CQC comment cards	Feedback included that there was positive clinical care and that the staff were caring but that it could be difficult to get an appointment and the telephone system was not effective.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
43507	282	115	40.8%	0.26%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	92.5%	89.8%	89.0%	No statistical variation
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)	89.4%	87.8%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence	95.1%	96.0%	95.6%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)				
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)	81.1%	85.0%	83.8%	No statistical variation

Any additional evidence or comments
The above results relate specifically to The Gillies and Overbridge practice prior to the practice merger in July 2018.

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

Any additional evidence
Prior to the practice merger in July 2018, the practice conducted a patient survey in April 2018 to get patient feedback on concerns they had regarding access. Following the result of the survey, the practice formulated an action plan which they reviewed in March 2019 to try and address the concerns raised. One of the resulting actions was that the practice's patient participation group (PPG) was lobbying the local bus service to introduce a circular route between the three practices. In the meantime, the PPG had devised a transport leaflet which was available in the practice's waiting rooms which showed the options available to patients.

Involvement in decisions about care and treatment

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

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

Source	Feedback
Interviews with patients.	Feedback from patients included that they were treated with dignity and respect but that getting a routine appointment could often be difficult and getting through on the phones for challenging.

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)	97.2%	94.1%	93.5%	No statistical variation

Any additional evidence or comments
The above results relate specifically to The Gillies and Overbridge practice prior to the practice merger in July 2018.

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

Carers	Narrative
Percentage and number of carers identified.	552 representing 1.2% of the patient list size.
How the practice supported carers.	The practice did not have a carer's notice board, but information leaflets were available on request from reception.
How the practice supported recently bereaved patients.	The practice didn't offer specific services for patients who were recently bereaved.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Responsive Rating: Requires improvement

Responding to and meeting people's needs

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

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y

Practice Opening Times	
Day	**Time**
Opening times: Across all three sites	
Monday	8.00am to 6.30pm
Tuesday	8.00am to 6.30pm
Wednesday	8.00am to 6.30pm
Thursday	8.00am to 6.30pm
Friday	8.00am to 6.30pm
Appointments available:	
Monday	8.00am to 6.30pm
Tuesday	8.00am to 6.30pm
Wednesday	8.00am to 6.30pm
Thursday	8.00am to 6.30pm
Friday	8.00am to 6.30pm
Improved access:	
Monday	6.30pm to 8.00pm
Tuesday	6.30pm to 8.00pm
Wednesday	6.30pm to 8.00pm
Thursday	6.30pm to 8.00pm
Friday	6.30pm to 8.00pm
Saturday	8.00am to 11.00am

National GP Survey results

Practice	Surveys sent out	Surveys returned	Survey Response	% of practice

population size			rate%	population
43507	282	115	40.8%	0.26%

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)	95.7%	94.5%	94.8%	No statistical variation

Any additional evidence or comments

The above results relate specifically to The Gillies and Overbridge practice prior to the practice merger in July 2018.

Older people

Population group rating: Requires Improvement

Findings

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

People with long-term conditions

Population group rating: Requires Improvement

Findings

- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Requires Improvement

Findings

- Additional nurse appointments were available until 8pm Monday to Friday and 8am to 11am on Saturdays for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those

Population group rating: Requires

recently retired and students) — Improvement

Findings
• The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. • The practice offered pre-bookable improved access clinics which ran Monday to Friday 6.30pm to 8.00pm and 8.00am to 11.00am on Saturdays.

People whose circumstances make them vulnerable — Population group rating: Requires Improvement

Findings
• The practice held a register of patients living in vulnerable circumstances including those with a learning disability. • People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode. • The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia) — Population group rating: Requires Improvement

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

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence: The practice had implemented a duty hub which was maintained by clinicians including GPs and	

advanced nurse practitioners. This meant that any patients requiring urgent appointments or home visits would have their needs assessed by a clinician.

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)	48.3%	N/A	70.3%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	60.7%	67.1%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	51.5%	61.4%	65.9%	No statistical variation
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)	66.6%	73.2%	74.4%	No statistical variation

Any additional evidence or comments
The above results relate specifically to The Gillies and Overbridge practice prior to the practice merger in July 2018. Patient feedback on inspection was in line with these findings and was negative about getting through to the practice on the phone. We discussed this with the practice who were aware that telephone access had been a problem for patients. They had raised this with the telephone company to see if there was a systemic problem as some patients would get through straight away to the practice while others would have a long wait. An error in the system was identified and fed back to the practice. Learning from this was disseminated to staff and the change implemented on the day of inspection. This change saw a drop in the number of abandoned calls to the practice. For example, the week beginning 18 February 2019 the number of calls abandoned represented 57% of the total number of calls taken that week. Following the change in process on 20 and 21 March 2019 of the total number of calls taken, 43% were abandoned.

Source	Feedback
NHS choices – average rating 2.5 out of 5 Gillies health centre – rated 2 out of 5 St Andrews – rated 2.5 out of 5	We reviewed all comments relating to the Gillies Health Centre, Essex House and St Andrews since the practice merger July 2018. Feedback included that staff were friendly and helpful but that it was difficult to get through to the practice on the phone.

Essex House – rated 2.5 out of 5	

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received since July 2018	77
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	5
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Partial
Explanation of any answers and additional evidence: We reviewed the practice's log of complaints received since July 2018 and found that the practice had missed opportunities for learning or to drive continuous improvement. Of the 77 complaints received, 26 were listed as 'no identified learning'. This included a complaint which related to repeated appointment cancellations. At the initial consultation the appointment had to be rescheduled as the clinician was unable to operate the required piece of equipment. The rescheduled appointment was then cancelled at short notice due to staff sickness when the patient was already on their way to the practice. No learning had been identified from this complaint.	

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient attended the practice for an appointment and checked in but was not made aware that his appointment was at a different site.	The patient was contacted and the practice apologised for this error. A change in process was implemented where receptionists would write the location of the appointment on the appointment cards handed to patients.

Well-led Rating: Requires Improvement

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: The practice had devised a five-year plan following the merger in July 2018. This identified actions such as standardising protocols and the recruitment of staff. Timescales were assigned to each action and it was colour coded to determine if that deadline would be met. Prior to inspection, the practice had run team building workshops to bring staff from across the three sites together.	

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

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
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y

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

Source	Feedback
CQC staff questionnaire	Feedback included that all staff were friendly and that a lot of work had gone into trying to bring everyone across the sites together. However, feedback also

	included that there wasn't enough staff and that not all staff received information about patient feedback.

Governance arrangements

There were responsibilities, roles and systems of accountability to support governance and management, but these were not embedded.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: We found that policies at the practice were not always easily accessible. The practice was in the process of updating policies and putting them on the new intranet system. However, we found that when requested, practice staff were not always able to access the policies required. We found that the practice's complaints policy and procedures did not ensure patients had all the necessary information should they wish to escalate their complaint further. The practice had not included in their policy details of the health service ombudsman and patients did not receive this information in response to their complaints. During inspection, the practice updated their complaints policy to ensure this information was included in response to complaints. Practice policies did not always reflect current guidelines. For example, the practice's safeguarding children policy did not identify the correct level of training for clinicians according to the intercollegiate guidance 2018. We found that recruitment checks were not consistent. We saw two staff files where there was no record of references prior to employment. The practice advised that they had received verbal references for the staff members but this had not been recorded.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
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.	N
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 did not maintain effective oversight of staff training. We reviewed training records and found	

that not all staff had completed training appropriate to their role and in line with practice policy.
There was no oversight of staff appraisals. Records showed that some staff had not received an appraisal since 2015.
Governance arrangements to mitigate risk were not embedded in practice. For example, for health and safety and Legionnella, we found that risk assessments had not been consistently conducted across all three sites and that processes to ensure that actions identified were completed was not consistent.

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.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: Practice risk assessments did not always accurately reflect possible concerns. For example, an item identified as requiring action on the practice's infection prevention and control (IPC) risk assessment had been marked as completed, however on further investigation, we found that this was not the case.	

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
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: Feedback from the patient participation group (PPG) included that they felt valued and included in the development of the practice. They had been active in trying to sort out concerns patients had regarding transport links between all sites and formulated a leaflet which was available in the reception areas with transport information.	

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation but these were not effective.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial

Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: The practice's process to identify learning from complaints was not always effective. We found a number of missed opportunities where learning could have been identified to drive improvement.	

Examples of continuous learning and improvement
The practice told us that they were in the process of creating a 'diabetic hub' which would include input from a diabetic consultant. This would enable patients with diabetes, including those with complex requirements, to have their needs met in the practice rather than having to be referred to secondary care. This service would also include retinal screening and a diabetes educational programme.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	No statistical variation	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
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.
- 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.

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

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

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.