Care Quality Commission

Inspection Evidence Table

Arbury Road Surgery (1-542699003)

Inspection date: 30 May 2019

Date of data download: 14 May 2019

Overall rating: Good

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

Safe Rating: Good

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
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).	Y
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

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance 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

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: December 2018	Y
There was a record of equipment calibration. Date of last calibration: December 2018	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: June 2018	Y
There was a log of fire drills. Date of last drill: March 2019	Y
There was a record of fire alarm checks. Date of last check: June 2018	Y
There was a record of fire training for staff. Date of last training: On-going training as per staff requirements	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: November 2018	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: • A legionella risk assessment was completed in May 2019.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: November 2018	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: November 2018	Y

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y[1]
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit: June 2018[3]	
The practice had acted on any issues identified in infection prevention and control audits.	Y[2]
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: 1 – At the previous inspection in June 2018, we found the infection prevention and control policy was brief and missing key information such as waste and sharps management. At this inspection we found the practice had reviewed their infection prevention and control policy and ensured it contained more information including waste and sharps management. 2 – At the previous inspection in June 2018, we noted there was dirt and dust on the floor in two treatment rooms. This was also highlighted in the audit completed one week prior to our inspection but no action had been taken to remedy this. At this inspection we found the practice had completed a review of infection prevention and control procedures and had employed a new external cleaning company. The practice completed regular audits of the cleaning standard at the practice. 3 – A new infection prevention control lead was in post and had planned to complete a new infection prevention control audit in June 2019.	

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
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[1]
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:

1 – We were told of a specific example of when a member of the administrative staff became aware of a patient attending the practice who may need additional support. Following this, the member of staff notified the clinical lead and the patient was signposted to appropriate support services.

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) (01/01/2018 to 31/12/2018) (NHS Business Service Authority - NHSBSA)	0.91	0.98	0.91	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2018 to 31/12/2018) (NHSBSA)	12.9%	11.9%	8.7%	Tending towards variation (negative)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2018 to 31/12/2018) (NHSBSA)	5.79	5.93	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/07/2018 to 31/12/2018) (NHSBSA)	2.25	2.13	2.13	No statistical variation

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

- The practice was aware they were higher than average prescribers of antibiotics. In order to reduce this additional educational tools were provided to clinicians, regular audits were completed and patients were encouraged to self-care. We saw evidence on the day of the inspection the practice's antibiotic prescribing rate had reduced but further work was required.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	15
Number of events that required action:	15

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Delayed patient referral	Investigation was completed by the practice, the patient was contacted and apologised to and this was discussed in practice meetings. The practice also shared this with the Clinical Commissioning Group.
Medical emergency	The practice reviewed their medical emergency processes, to ensure all appropriate staff are informed of a medical emergency. This was discussed during practice meetings.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y[1]
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: 1 – Alerts were received into the practice and distributed amongst clinicians by the practice management; appropriate actions were taken and relevant information was sent to other staff via notifications on the practice computer system as appropriate.	

Effective Rating: Requires Improvement

The practice was rated as requires improvement for providing effective services because:

- The practice's uptake of cervical screening was below the 80% Public Health England target rate and below CCG and England averages.
- The practice's uptake of childhood immunisations was below the 90% World Health Organisation target rate and the practice told us this rate had reduced further in unpublished data.
- The practice's performance for outcomes for patients experiencing poor mental health was mixed and the practice told us this rate had reduced further in unpublished data. The practice's exception reporting rate for mental health indicators was also higher than the CCG and England averages.
- The practice had only completed 4 health checks out of 79 eligible patients diagnosed with a learning disability.

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

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2018 to 31/12/2018) (NHSBSA)	1.14	0.84	0.79	No statistical variation

Older people — Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- 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.
- All patients had a named GP, including those patients in a residential care home.
- Older patients who lived in care homes received flu vaccinations during home visits.
- Clinical staff visited allocated care homes on a regular basis. Care home staff knew how to contact them if they had any concerns.

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 care professionals to deliver a coordinated package of care.
- The practice's performance for long-term conditions was generally in line with CCG and England averages. The practice was aware of a higher than CCG and England average exception reporting rate for patients diagnosed with diabetes, asthma and COPD. The practice had reviewed their exception reporting rate and had identified changes to their patient recall system to improve this.
- The practice was reviewing and improving their recall system following a recent recruitment drive and restructuring of their nursing team.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- 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.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. For example, nursing staff had completed diplomas in diabetes and respiratory care.
- Patients who were housebound received home visits for their annual review.

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)	80.2%	80.5%	78.8%	No statistical variation
Exception rate (number of exceptions).	23.0% (130)	15.7%	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)	86.3%	74.4%	77.7%	No statistical variation
Exception rate (number of exceptions).	12.4% (70)	11.9%	9.8%	N/A
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	80.8%	79.3%	80.1%	No statistical variation
Exception rate (number of exceptions).	18.1% (102)	15.5%	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)	70.6%	76.2%	76.0%	No statistical variation
Exception rate (number of exceptions).	12.6% (108)	7.9%	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)	91.4%	90.8%	89.7%	No statistical variation
Exception rate (number of exceptions).	19.6% (51)	13.6%	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)	81.3%	82.2%	82.6%	No statistical variation
Exception rate (number of exceptions).	6.2% (84)	4.7%	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)	82.8%	90.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	3.6% (6)	7.6%	6.7%	N/A

Families, children and young people

Population group rating: Requires Improvement

Findings

We rated the practice as requires improvement for providing effective care to families, children and young people because:

- Childhood immunisation uptake rates were below the World Health Organisation (WHO) target rate of 90%. The practice told us recent data evidenced more deterioration in the uptake. The practice was monitoring the uptake of childhood immunisations and believed this was in part due to different cultures within the practice population. To improve this uptake, the practice planned to translate invitation letters into the parent's first language where necessary additional information was planned to be included on their website and social media to encourage uptake.
- 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 and would liaise with health visitors when necessary.
- The practice facilitated midwives and health visitors holding clinics at the practice.
- 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)	128	143	89.5%	Below 90% minimum (variation negative)
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)	135	152	88.8%	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)	133	152	87.5%	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)	135	152	88.8%	Below 90% minimum (variation negative)

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice's uptake of cervical screening was lower than the CCG and England averages and below the 80% Public Health England target rate; this performance was also lower than the performance from the previous inspection. The practice told us of their plans to improve this rate, including the restructuring and recruitment of a new nursing team and a more flexible approach for patients attending for cervical screening.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

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)	58.2%	70.9%	71.7%	Variation (negative)
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	62.7%	73.4%	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)	49.1%	56.9%	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)	24.0%	63.0%	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)	51.2%	60.6%	51.9%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

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 and those with a learning disability.
- The practice had identified 79 patients who were diagnosed with a learning disability. Of these 79 patients, four had received a health check within the previous 12 months. The practice identified that low staffing levels accounted for the low number of health checks completed.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings
• The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. • The practice's Quality Outcomes Framework performance was mixed for mental health indicators. The number of patients diagnosed with dementia who had a face-to-face review, was lower than the CCG and England averages. The practice was aware of this and shared their plans of improvement with us. • The practice was aware of a higher than CCG and England average exception reporting rate for patients with a mental health condition. The practice had reviewed their exception reporting rate and had identified changes to their patient recall system to improve this. • There was a system for following up patients who failed to attend for administration of long-term medication. • When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. • Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. • All staff had received dementia training in the last 12 months.

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)	95.2%	91.0%	89.5%	No statistical variation
Exception rate (number of exceptions).	30.0% (45)	13.1%	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)	85.3%	89.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	22.7% (34)	11.7%	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)	75.8%	85.0%	83.0%	No statistical variation
Exception rate (number of exceptions).	1.6% (1)	6.6%	6.6%	N/A

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)	549.6	543.0	537.5
Overall QOF exception reporting (all domains)	11.9%	6.5%	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 was aware their antibiotic prescribing was higher than CCG and England averages and had completed a series of audits to identify why it was higher and how it could be reduced. These audits evidenced some improvements to the antibiotic prescribing rates, but further work was required. • The practice provided us with examples of two, two-cycle audits. One of these audits reviewed the prescribing of two medicines which should not be prescribed together (Simvastatin and Amlodipine) following a patient drug safety alert. On the first cycle, 12 patients were identified, and were recalled to have a review of their medication. On the second cycle of the audit, all of these patients had been prescribed alternative medicines, which was a 100% success rate.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018)	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.	N/A

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[1]
Explanation of any answers and additional evidence: 1 – We found evidence of literature including posters and leaflets in the patient waiting areas for national campaigns such as smoking cessation and weight loss. In addition to this, the practice advertised local support services and groups for patients such as those experiencing poor mental health and carers.	

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)	92.6%	95.3%	95.1%	No statistical variation
Exception rate (number of exceptions).	1.7% (42)	0.9%	0.8%	N/A

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y

Well-led Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y[1]
There was a leadership development programme, including a succession plan.	Y[2]
Explanation of any answers and additional evidence: 1 – Members of staff we spoke with reported a positive working environment and told us they felt well supported by the practice leadership team. They reported that they felt comfortable to raise concerns and leaders were visible, approachable and operated an open-door policy. 2 – The practice was in the process of joining a Primary Care Network (PCN) with four other local practices. The practice had met with their PCN group to consider future actions and working relationships.	

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[1]
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
Explanation of any answers and additional evidence: 1 – The practice had completed an anonymous well-being survey of their staff team shortly prior to our inspection. The results of this survey were due to be analysed and the leadership team planned to meet to discuss any actions that were required.	

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

Source	Feedback
Staff consultations	Staff we spoke with reported a positive working environment and told us they felt well supported by the practice leadership team. We spoke with a recently recruited member of staff who told us they felt well inducted and supported into their role. Staff told us there was a good morale amongst the staff team and teams worked well together to deliver good patient care. Staff reported that during the previous year, due to recruitment difficulties, teams supported each other effectively to continue to deliver the service.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y[1]
Staff were clear about their roles and responsibilities.	Y[2]
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: 1 – GP partners had lead roles in a range of areas; for example, prescribing, the quality and outcomes framework and safeguarding. Staff were aware of these lead roles. Two of the GPs also had extra training in specialist areas for example ENT, Dermatology and Gynaecology. 2 – Members of staff we spoke with were clear about their roles and responsibilities and were satisfied with them. There was a clear escalation process and lead roles for key areas of work.	

Managing risks, issues and performance

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

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

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[1]
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: 1 – The practice was aware of a decline in performance in Quality Outcomes Framework indicators. The practice told us their plans to improve this performance, built around a new nursing team structure. These plans were realistic and improvements to this would be reviewed at the next inspection.	

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

Continuous improvement and innovation

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

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

Examples of continuous learning and improvement
• The practice had a clinical and non-clinical audit program to ensure the quality of care is monitored and improved where necessary. • Practice nurses were supported by the practice to gain additional qualifications such as minor illness and injury. • A telephone triage chart had been implemented for administrative staff to ensure patients are correctly signposted to the most appropriate clinician or service. • The practice had started to have student nurses on their training placements from university. • The practice is a training practice for medical students and GP registrars. (A GP registrar is a qualified doctor who is training to become a GP).

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- 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.