Care Quality Commission

Inspection Evidence Table

Dr P K Mohanty and Partners (1-2327638331)

Inspection date: 30th May 2019

Date of data download: 16 April 2019

Overall rating: Requires Improvement

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

Safe Rating: Requires Improvement

We have rated this practice as requires improvement for providing safe services because fire training was outdated for some staff and training for infection control had expired for the member of staff who was the lead in this area. We also found that no infection control audit had been carried out. On the day of the inspection we also found that PAT testing had expired and checks for the high-risk medication Lithium were not being carried out.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse however some areas relating to health and safety needed to be addressed.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	YES
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	YES
There were policies covering adult and child safeguarding.	YES
Policies took account of patients accessing any online services.	YES
Policies and procedures were monitored, reviewed and updated.	YES
Policies were accessible to all staff.	YES
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	YES
There was active and appropriate engagement in local safeguarding processes.	YES
There were systems to identify vulnerable patients on record.	YES
There was a risk register of specific patients.	YES
Disclosure and Barring Service (DBS) checks were undertaken where required.	YES

Safeguarding	Y/N/Partial
Staff who acted as chaperones were trained for their role.	YES
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.	YES

Explanation of any answers and additional evidence:

- Safeguarding systems, processes and practices had been developed, implemented and communicated to staff. Electronic pop-up alerts had been placed on the relevant patient records, so clinicians were made aware of any safeguarding issues when accessing the file.
- Staff were trained in safeguarding appropriate to their role. Staff were able to talk us through the steps they would follow if they had safeguarding concerns.
- The practice had an appointed safeguarding primary care lead and a deputy safeguarding lead.
- The practice shared the building with community services including community matrons and safeguarding concerns were often discussed with them when needed.
- Staff who acted as chaperones were trained for the role and had received a DBS check. Two members of non-clinical staff had received chaperone training (one male and one female).
- Any safeguarding concerns were discussed at weekly clinical meetings which were held every Monday.
- Practice specific policies were in place for safeguarding and the lead and deputy lead was clearly stated on these policies which were available to all staff on the shared drive. Staff were aware of how to access these policies.
- On the day of the inspection we saw examples of 'flags' on patient records if there had been an issue relating to abuse.

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

Explanation of any answers and additional evidence:

- The practice used one locum who was known to staff and covered any long periods of annual leave. Evidence on the day of the inspection showed that DBS checks had been carried out, copies of certificates had been obtained and evidence of GMC registration and medical indemnity was available for this locum member of staff.
- An induction update was given to the locum upon arrival at the practice and included 30 minutes with the practice manager to advised on changes that had occurred since the last time they had worked at the practice.
- All new starters had a full induction and a checklist was completed to ensure all the necessary security checks had been carried out.
- Files for two members of staff were seen on the day of the inspection. These contained all the relevant information.

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: October 2015	Partial
There was a record of equipment calibration. Date of last calibration: November 2018	YES
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	YES
There was a fire procedure.	YES
There was a record of fire extinguisher checks. Date of last check: August 2018	YES
There was a log of fire drills. Date of last drill: 17 April 2019	YES
There was a record of fire alarm checks. Date of last check: 30th May 2019	YES
There was a record of fire training for staff. Date of last training: April 2018	Partial
There were fire marshals.	YES
A fire risk assessment had been completed. Date of completion: 09/03/2018	YES
Actions from fire risk assessment were identified and completed.	Partial

Explanation of any answers and additional evidence:

- On the day of the inspection we found that PAT testing was last carried out in October 2015. The practice told us they were currently in the process of arranging a company to come in and further evidence submitted since the inspection showed that PAT testing had been arranged to take place on the 12th June 2019.
- The practice was in a shared building and management of this was carried out by NHS property services who were responsible for the maintenance of the building.

- The practice had carried out its own fire risk assessment and actions were identified from this which were submitted to NHS property services for actioning. Actions identified included more lighting at one of the fire exits and for moss to be cleared at the bottom of the steps from the upstairs fire exist due to a slip hazard. On the day of the inspection these were still outstanding however actions identified on the full fire risk assessment carried out by NHS property services had been actioned.
- One the day of the inspection we found that online fire training had last took place for some members of in April 2018 and was therefore due to be updated.
- Fire alarm checks were carried out on a weekly basis.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: August 2017	YES
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: August 2017	YES

Explanation of any answers and additional evidence:

- The health and safety audit was carried out by NHS property services and related to the entire building and not just the areas used by the GP service. Actions identified from this audit had been actioned.
- The practice had undertaken their own cleaning audit as they were unhappy with the standard of cleaning within the building. This was submitted to NHS property services and because of this the contract was given to an alternative company.
- The practice had a practice specific health and safety policy in place.

Infection prevention and control

	Y/N/Partial
There was an infection risk assessment and policy.	YES
Staff had received effective training on infection prevention and control.	PARTIAL
Date of last infection prevention and control audit: October 2018	NO
The practice had acted on any issues identified in infection prevention and control audits.	NO
The arrangements for managing waste and clinical specimens kept people safe.	YES

Explanation of any answers and additional evidence:

Explanation of any answers and additional evidence:

- The practice nurse was the lead for infection prevention and control. On the day of the inspection we found that infection control training had expired in April for this member of staff.
- No practice specific infection control audit had been carried out.
- The managing of waste and clinical specimens was dealt with by NHS property services. The practice had carried out a questionnaire on behalf of NHS property services relating to the disposal of clinical waste and included questions on the correct bags. Evidence of this questionnaire that was seen on the day of the inspection showed that the practice was clear on the correct procedures.

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

When there were changes to services or staff the practice assessed and monitored the impact on safety.	YES

Explanation of any answers and additional evidence:

- There was an effective approach to managing staff absences. Reception staff covered each other during busier times or during annual leave and were paid overtime for any extra work undertaken. The practice also used a locum member of staff to cover the GP's if they were going on a longer period of annual leave.
- Administrative and clinical staff had access to the panic alarms held on the computer system and all staff members were clear on how to use this.
- The reception team had access to an emergency room whereby if they encountered someone who they felt were acutely unwell or appeared to be deteriorating then a clinician would be alerted immediately, and the use of this room could be accessed. This was located next to the nurse's room where they could be monitored closely.
- Sepsis information was available to administration and clinical staff. A patient information sheet was displayed in the reception area and the practice had a Sepsis lead.
- Equipment for the assessment of sepsis was available, this included a paediatric pulse oximeter.
- Staff would get a warning to check for further signs or symptoms of Sepsis via their computer system if a symptom relating to sepsis was inputted.

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

Explanation of any answers and additional evidence:

- Pathology results were checked at the start of each day by admin staff. These were then allocated to the referring GP for actioning.
- One member of staff was responsible for the summarising of all patient notes.
- Referrals were managed by the central referral system (CRS). GP's would task a member of the admin team to put a referral letter in place which was then uploaded directly to CRS. It was then sent out to the patient directly with details of how to choose and book.
- On the day of the inspection we were told that the referrals team were due to come into the practice to provide staff with more information about how the CRS system works.

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)	1.00	1.01	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)	8.5%	10.9%	8.7%	No statistical variation
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)	7.24	5.63	5.60	Variation (negative)
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)	1.24	1.92	2.13	Tending towards variation (positive)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	YES
Blank prescriptions were kept securely and their use monitored in line with national guidance.	YES
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	YES
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.	YES
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	YES
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	YES

Medicines management	Y/N/Partial
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.	PARTIAL
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	NO
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	YES
If the practice had controlled drugs on the premises there were 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.	YES
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	YES
For remote or online prescribing there were effective protocols for verifying patient identity.	YES
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.	YES
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	YES
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	YES
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	YES

Explanation of any answers and additional evidence:

- Monthly reports were carried out for the monitoring of high-risk medications. Patients were contacted by phone, text or letter when they blood testing was due and medications were not issued without this. Records we checked on the day showed that there was effective governance and a recall system in place for high risk medications however we did find that lithium was not checked on the monthly audit. Since the inspection the practice has provided us with information that a separate monthly report for lithium is now in place and is automatically tasked to the nurse along with the other reports.
- The practice had its own in-house Warfarin clinic. The INR results were sent to the GP who would review the dose and contact the patient with the updated dosage. Examples of this were seen on the day.
- On the day of the inspection we found that the practice's cold chain procedure was effective, and a clear log of the temperature ranges were documented.
- Staff were able to state what action they would take if any of the temperatures were outside the normal ranges and who was responsible for checking the fridges, including who else would do it in the event if the allocated person was not there.
- As the building was shared with community services the practice had access to an alternative fridge if there were any problems. This has been agreed between the practice and the community services.
- Emergency drugs were checked once per month by the nursing staff. On the day of the

Medicines management	Y/N/Partial
inspection we found that some emergency drugs were out of date. The practice was aware of this and were waiting for collection and disposal of these. • On the day of the inspection we found that the practice had no patient specific controlled drugs book to record the details of the controlled drugs that had been administered. • The clinical pharmacist was looking into the practices repeat prescribing. • The practice had a signed agreement for controlled drugs which were on the records of patients who may misuse these. We asked the practice about their higher than average prescribing 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 infections. We were told that they were aware of the data and they had been working closely with the clinical pharmacist with an aim to reduce these figures.	

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.	YES
Staff knew how to identify and report concerns, safety incidents and near misses.	YES
There was a system for recording and acting on significant events.	YES
Staff understood how to raise concerns and report incidents both internally and externally.	YES
There was evidence of learning and dissemination of information.	YES
Number of events recorded in last 12 months:	0
Number of events that required action:	0

Explanation of any answers and additional evidence:

- The practice had identified six learning outcomes in the last 12 months. These events were not escalated to significant events as they were discussed at clinical meetings and decisions were made going forward to resolve the problem and to identify any learning outcomes.
- Learning events were discussed and meetings. We saw evidence of the minutes from these meetings on the day of the inspection. Learning outcomes were discussed with all staff on an informal basis and then again at length during practice meetings that were held every 3 months.
- Significant events were dealt with immediately if necessary.

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

Event	Specific action taken
Patient did not want to see a certain GP again as was unhappy with the outcome at the last appointment.	The practice manager spoke with the patient and assured them they did not have to be seen by that GP again. An alert was then placed on the patients file to ensure she is not booked in with this clinician when requesting appointments.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	PARTIAL
Staff understood how to deal with alerts.	YES

Explanation of any answers and additional evidence:

- Safety alerts were sent to the practice nurse. This was then reviewed and if relevant it was sent to all clinical staff and added onto a spreadsheet which was kept on the shared drive and could be accessed by all staff. However, we found that the system was not monitored effectively to ensure that the relevant action had been taken. Since the inspection we have been told that the practice manager now also receives the safety alerts so there is an additional person to monitor and distribute them in the event the practice nurse was not available.
- On the day of the inspection we carried out a search relating to two safety alerts and found that

these had not been acted upon, however the GPs were aware of these alerts.

Effective Rating: Require Improvement

This practice has been rated as requires improvement for providing effective services due to low QOF data relating to patients with long term conditions, those experiencing poor mental health and working age people.

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.	YES
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	YES
We saw no evidence of discrimination when staff made care and treatment decisions.	YES
Patients' treatment was regularly reviewed and updated.	YES
There were appropriate referral pathways were in place to make sure that patients' needs were addressed.	YES
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	YES

Explanation of any answers and additional evidence:

- GPs were aware of relevant and current evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practices guidelines. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patient's needs.
- The practice had implemented a 'birth month' recall system whereby patients were contacted during the month of their birthday for reviews and this provided a tracking system as to who had been contacted. This had only recently been implemented.
- Patients who were due a review also had a 'tagged' label attached to their file, so GP's were alerted to this during appointments providing opportunistic reviews

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)	1.83	0.95	0.79	Variation (negative)

Additional Information:

The practice was unaware of their higher than average daily quantity of Hypnotics prescribed per specific therapeutic group.

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.
- 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: Requires Improvement

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.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

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)	55.6%	74.4%	78.8%	Significant Variation (negative)
Exception rate (number of exceptions).	4.9% (17)	12.1%	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)	66.2%	69.7%	77.7%	Tending towards variation (negative)
Exception rate (number of exceptions).	5.7% (20)	9.0%	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)	53.3%	73.3%	80.1%	Significant Variation (negative)
Exception rate (number of exceptions).	7.2% (25)	12.8%	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)	67.4%	74.1%	76.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	1.6% (5)	8.2%	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)	76.1%	89.3%	89.7%	Variation (negative)
Exception rate (number of exceptions).	6.6% (10)	14.9%	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)	72.8%	81.3%	82.6%	Variation (negative)
Exception rate (number of exceptions).	3.9% (31)	3.9%	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)	95.6%	89.9%	90.0%	No statistical variation
Exception rate (number of exceptions).	10.0% (5)	5.0%	6.7%	N/A

Any additional evidence or comments

- Unverified QOF data for the year 2018/19 showed an increase from 55.6% to 56.9% for 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.
- Unverified QOF data from 2018/19 showed an increase from 66.2% to 68.7% for 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.
- Unverified QOF data from 2018/19 showed an increase from 53.3% to 59.5% for 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.
- Unverified QOF data from 2018/19 showed an increase from 53.3% to 59.5% for 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.
- Unverified QOF data from 2018/19 showed a decrease from 76.1% to 61.8% for the percentage of patients with COPD on the register, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months
- Unverified QOF data from 2018/19 showed a decrease from 72.8% to 68.4% for the percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less.

The practice had recently implemented a recall plan based on the patient's birth month whereby patients in need of a review were contacted during their birth month to make an appointment. This also provided a way of tracking who had been contacted.

Although we found that unverified data had slightly improved from the QOF year of 2017/2018 in some areas we found that there had been a downward trend compared to the data collected at our inspection in 2017.

Families, children and young people Population group rating: Good

Findings

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets.
- 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)	89	90	98.9%	Met 95% WHO based target (significant variation positive)
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)	103	113	91.2%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	104	113	92.0%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	104	113	92.0%	Met 90% minimum (no variation)

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- 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.
- The practice had an electronic BP machine in the waiting area for all patients to use.

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)	72.0%	73.8%	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)	70.3%	70.1%	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)	48.0%	57.9%	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)	64.5%	63.7%	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)	48.3%	54.3%	51.9%	No statistical variation

Any additional evidence or comments

- The percentage of persons aged 60-69 screened for bowel cancer was below local and national averages and also for the number of new cancer cases treated, which resulted from a two week wait referral. On the day of the inspection we were told that one of the GPs was responsible for carrying out the follow ups for bowel screening.

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. End of life meetings were held every 3 months.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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.
- 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.
- Those patients who were known to have drug addiction had a strict prescription policy.
- There was a DNA process in place for those patients prescribed a depot injection relating to their mental health diagnosis.
- 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.
- Leaflets were sent to patients to help support them with their 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)	63.8%	85.2%	89.5%	Variation (negative)
Exception rate (number of exceptions).	2.1% (1)	17.6%	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)	59.6%	79.4%	90.0%	Significant Variation (negative)
Exception rate (number of exceptions).	2.1% (1)	16.4%	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)	75.0%	83.3%	83.0%	No statistical variation
Exception rate (number of exceptions).	6.4% (3)	9.3%	6.6%	N/A

Any additional evidence or comments

- Unverified QOF data for the year 2018/19 showed a decrease from 63.8% to 58.4% for 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.
- Unverified QOF data for the year 2018/19 showed an increase from 59.6% to 75.0% for the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months.

Although we found that unverified data had slightly improved from the QOF year of 2017/2018 in one area we found that there had been a downward trend compared to the data collected at our inspection in 2017.

The practice had recently implemented a recall plan based on the patient's birth month whereby patients in need of a review were contacted during their birth month to make an appointment. This also provided a way of tracking who had been contacted.

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/There was limited monitoring of the outcomes of care and treatment.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	451.2	529.0	537.5
Overall QOF exception reporting (all domains)	3.6%	5.2%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	YES
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Partial

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

- The practice regularly ran an audit relating to their minor operations. The purpose of this audit was to check if any infections had occurred in the 4 weeks following the surgery.
- The practice was aware that they needed to carry out more clinical audits and they have plans in place for this going forward.

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.	YES
The learning and development needs of staff were assessed.	YES
The practice had a programme of learning and development.	YES
Staff had protected time for learning and development.	YES
There was an induction programme for new staff.	YES
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	YES
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.	YES
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	YES
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	YES

Explanation of any answers and additional evidence:

- The practice had a half day closure every month for staff to undertake further training.
- In the last 12 months the practice had started to use the Bluestream Academy which was a learning system were staff could carry out learning online and helped to identify who was due to training or when training was about to expire.

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)	YES
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.	YES
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	YES
Patients received consistent, coordinated, person-centred care when they moved between services.	YES
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	YES

Explanation of any answers and additional evidence:

- On the day of the inspection we saw evidence that action plans discussed at MDT meetings were placed on the patients records. The GP would tasked themselves to follow up on these actions.
- The practice nurses had informal meetings between themselves daily and discussed anything they felt was relevant.
- The practice had close working relationships with other services such as heath visitors, district nursing teams and midwives.
- One of the practice nurses had taken the lead on COPD reviews and had worked closely with Essex Lifestyle Services who offer smoking cessation services. Staff can also refer to this service for other services such as weight management.
- The practice was involved with the Global Initiative for Chronic Obstructive Lung Disease (GOLD).

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.	YES
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	YES
Staff discussed changes to care or treatment with patients and their carers as necessary.	YES
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	YES
Explanation of any answers and additional evidence: • The practice used Ardens templates, which ensured localised standardised care is provided with supporting clinical pathways, for patients in the last 12 months of their life. • Palliative care meetings were held every 3 months and frailty meetings were held on a monthly basis.	

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)	94.5%	94.2%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.4% (6)	0.8%	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.	YES
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	YES
The practice monitored the process for seeking consent appropriately.	YES
Explanation of any answers and additional evidence: • On the day of the inspection we saw evidence that consent forms had been completed and we also saw examples of shared decision making between clinician and patient.	

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.	YES
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	YES
Explanation of any answers and additional evidence:	

CQC comments cards	
Total comments cards received.	26
Number of CQC comments received which were positive about the service.	26
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comment Cards	All comment cards received were positive. Comments included that it was a good service with polite, helpful and friendly staff. Comments also state that they were able to get appointments quickly and that the premises were always clean and tidy.

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
5921	309	108	35%	1.82%

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)	79.4%	86.6%	89.0%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018)	80.9%	85.0%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	91.8%	94.7%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	75.1%	79.0%	83.8%	No statistical variation

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

Any additional evidence
• The practice had carried out its own patient survey in May 2018 over the space of a week. They had received approximately 100 responses with the majority stating the service they had received was excellent. • The iplato system had recently been implemented and via this system a text message was sent to the patient following their appointment asking them to rate their experience via the friends and family test. The practice had found that the uptake of responses had been positive, and any negative responses were acted upon. Results were available for all staff to view. We were provided with evidence on the day of the inspection of the results from April and March. The amount of responses to the question 'would you recommend this service to friends and family?' for the month of April 2019 were as follows: • Extremely Likely: 18 • Likely:14 • Neither Way: 1 • Unlikely: 3 • Extremely Unlikely: 0 • Don't Know: 0 They looked at the same results for the month of March 2019: • Extremely Likely: 15 • Likely:13 • Neither Way: 1 • Unlikely: 3 • Extremely Unlikely: 2 • Don't Know: 2

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.	YES
Staff helped patients and their carers find further information and access community and advocacy services.	YES
Explanation of any answers and additional evidence:	

Source	Feedback
Interviews with patients.	On the day of the inspection we spoke with one patient. They reported that they were very happy with the service they had received and found all the staff to be pleasant and helpful.

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)	78.4%	93.0%	93.5%	Variation (negative)

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	YES
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	YES
Information leaflets were available in other languages and in easy read format.	NO
Information about support groups was available on the practice website.	YES

Explanation of any answers and additional evidence:

- The practice used a telephone interpretation service. Details of how to access this were in all the clinical rooms and in the reception area.
- The new patient registration forms asked what the patients first language was so the practice was aware if English was not their first Language. If a family member was interpreting on behalf of the patient, then a separate form was signed to confirm the patient gave permission for this due to confidentiality reasons.

Carers	Narrative
Percentage and number of carers identified.	The practice had 30 carers. There total patient list size on the day of the inspection was 5981. The carers therefore equate to 0.5% of their list size.
How the practice supported carers.	Carers were supported with information from Essex Carers which were available in the waiting room. The waiting room also had posters displayed asking if they were carer and to make themselves known to reception staff. New patient registration forms ask if the patient was a carer. All carers were offered health checks and support. Flexible appointment times were offered to those who were carers.
How the practice supported recently bereaved patients.	Information was available to the family if needed.

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.	YES
Consultation and treatment room doors were closed during consultations.	YES
A private room was available if patients were distressed or wanted to discuss sensitive issues.	YES
There were arrangements to ensure confidentiality at the reception desk.	YES
Explanation of any answers and additional evidence: • Next to the nurse's room there was an emergency room where unwell patients could sit. This room was also used as a quiet space for those patients who appeared distressed and didn't want to sit in the main waiting area.	

Responsive Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs/ Services did not meet patients' needs.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	YES
The facilities and premises were appropriate for the services being delivered.	YES
The practice made reasonable adjustments when patients found it hard to access services.	YES
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.	YES
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	YES
Explanation of any answers and additional evidence:	

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am – 6pm
Tuesday	8am – 6pm
Wednesday	8am – 6pm
Thursday	8am – 6pm
Friday	8am – 6pm
Appointments available:	
Monday	8am – 5.50pm
Tuesday	8am – 5.50pm
Wednesday	8am – 5.50pm
Thursday	8am – 6pm
Friday	9am – 17.50pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5921	309	108	35%	1.82%

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)	95.0%	93.9%	94.8%	No statistical variation

Any additional evidence or comments

Older people — Population group rating: Good

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.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

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

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- 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: Good

Findings

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students) — Population group rating: Good

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.

People whose circumstances make them vulnerable — Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- 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: Good

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.	YES
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	YES
Appointments, care and treatment were only cancelled or delayed when necessary.	YES
Explanation of any answers and additional evidence:	

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)	81.2%	N/A	70.3%	No statistical variation
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)	76.4%	60.0%	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)	68.2%	58.0%	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)	78.9%	70.8%	74.4%	No statistical variation

Any additional evidence or comments
• Appointments were released on the day at 8am and at 12pm. • A certain amount of appointments was pre-bookable, for example those for reviews of long-term conditions.

Source	Feedback
NHS Choices	Currently rated as 3.5 out of 5. 14 reviews have been left in the last 12 months with a mix of positive and negative feedback. Positive comments report that the practice was caring, understanding and they were able to get appointments easily. Negative comments relate to difficulty getting through on the phone and staff attitude.

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	10
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	YES
There was evidence that complaints were used to drive continuous improvement.	YES
Explanation of any answers and additional evidence: • The complaints policy stated that complaints were to be acknowledged within 10 days. We saw evidence that this had been upheld. • Complaints were discussed at meetings and informally between staff concerned if relevant. • Learning from complaints was shared between all staff members.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Complaint regarding a family member who had passed away and wanted to know if the practice could have done more and why an urgent referral was not sent. This complaint came via NHS England.	Investigated by NHS England with no clinical errors established, however the practice feels that communication could have been better, and they have taken steps to improve this because of this complaint.
Patient made emergency appointment but waited 50 minutes past appointment time and wasn't happy with outcome of the appointment.	GP spoken to about concerns and made aware of how patient felt and reminded them and to all staff about the importance of communication. Patients are now made aware when arriving for their appointments if a GP is running late.

Well-led Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	YES
They had identified the actions necessary to address these challenges.	YES
Staff reported that leaders were visible and approachable.	YES
There was a leadership development programme, including a succession plan.	YES
Explanation of any answers and additional evidence: • Staff we spoke to on the day of the inspection stated that they felt happy in their roles and that leaders were approachable.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	YES
There was a realistic strategy to achieve their priorities.	YES
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	YES
Staff knew and understood the vision, values and strategy and their role in achieving them.	YES
Progress against delivery of the strategy was monitored.	YES
Explanation of any answers and additional evidence: • One of the partners at the practice had undertaken a leadership and management course and was also part of the local medical council.	

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.	YES
Staff reported that they felt able to raise concerns without fear of retribution.	YES
There was a strong emphasis on the safety and well-being of staff.	YES
There were systems to ensure compliance with the requirements of the duty of candour.	YES
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	YES
Explanation of any answers and additional evidence:	

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

Source	Feedback
Staff Members	• Staff we spoke to on the day of the inspection stated that they felt happy in their roles and that leaders were approachable.

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.	YES
Staff were clear about their roles and responsibilities.	YES
There were appropriate governance arrangements with third parties.	YES
Explanation of any answers and additional evidence:	

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.	YES
There were processes to manage performance.	YES
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	YES
A major incident plan was in place.	YES
Staff were trained in preparation for major incidents.	YES
When considering service developments or changes, the impact on quality and sustainability was assessed.	YES
Explanation of any answers and additional evidence: • On the day of the inspection we saw evidence of an audit relating to the 2ww (Two Week Wait referrals) which was well conducted. Audits were mostly carried out by the pharmacists however one of the GP partners has a plan to start carrying out more clinical audits. • The practice had acted upon issues that were raised at our inspection in 2017 which included ensuring that they had a more robust system for dissemination of information and shared learning relating to significant events and complaints. Discussions were held with individual members involved and also at practice meetings. • They were aware of their lower than average QOF data in some areas and had recently implemented a recall system relating to reviews for patients who required them with an aim to Improve their performance. • Although we have acknowledged that many improvements had been made since the last inspection, further improvements were required.	

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.	YES
Performance information was used to hold staff and management to account.	YES
Our inspection indicated that information was accurate, valid, reliable and timely.	YES
There were effective arrangements for identifying, managing and mitigating risks.	YES
Staff whose responsibilities included making statutory notifications understood what this entails.	YES
Explanation of any answers and additional evidence:	

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.	YES
Staff views were reflected in the planning and delivery of services.	YES
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	YES
Explanation of any answers and additional evidence: • The practice had a close working relationship with the Clinical Commissioning Group and the Local Medical Council. • The practice had a plan to start an early morning extended hours service.	

Feedback from Patient Participation Group.

Feedback
• The practice had run a campaign to establish a more robust Patient Participation Group (PPG) due to a previously poor uptake. Posters and information were put up in the reception area and messages were sent out to people who had previously shown an interest however the practice told us that they were struggling to recruit more members. The practice had considered becoming a virtual PPG with the current 8 members who correspond via email often but find it difficult to get to meetings.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	YES
Learning was shared effectively and used to make improvements.	YES
Explanation of any answers and additional evidence: • Learning from complaints and significant events were shared between all staff.	

- One of the GP partners used practice meetings as an opportunity to carry out more training for staff. They recently had further training on Sepsis awareness.

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.