Care Quality Commission

Inspection Evidence Table

ANERLEY SURGERY (G84624)

Inspection date: 26 June 2019

Date of data download: 16 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.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Policies were in place 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
Systems were in place 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
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	Yes

Safeguarding	Y/N/Partial
workers. to support and protect adults and children at risk of significant harm.	

Explanation of any answers and additional evidence:

Previous CQC inspection 31 October 2018

- At our previous inspection in October 2018 there were no Disclosure and Barring Service (DBS) checks obtained for two members of staff who were undertaking chaperone duties. The practice manager had told us he was in the process of obtaining DBS checks, we were not shown any evidence of this. We had been told these staff members were not undertaking chaperoning duties, only the practice manager or other staff members that had a DBS check had been acting as chaperones. However, when we spoke with one non-clinical staff member they confirmed they had been undertaking chaperone duties and had not had a DBS check

CQC inspection 26 June 2019

- At this inspection we reviewed five staff files, all staff files had DBS checks we saw the practice manager now had an enhanced DBS check. All non-clinical staff who were undertaking chaperoning now had a DBS check done.
- All staff spoken to knew who the safeguarding lead was.
- Since the last inspection the practice had started using a consultancy company to produce its policies. All polices we looked at had been reviewed, we saw a policy covering adult and child safeguarding.

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

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: September 2018	Yes
There was a record of equipment calibration. Date of last calibration: September 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: January 2019	Yes
There was a log of fire drills. Date of last drill: January 2019	Yes
There was a record of fire alarm checks. Date of last check: June 2019	Yes
There was a record of fire training for staff. Date of last training: April 2019	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: June 2019	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence:	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: May 2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Yes
Explanation of any answers and additional evidence: **Previous CQC 31 inspection October 2018** At the previous inspection we found gaps in systems to manage risks to patient safety, there was limited evidence the practice had documented actions taken in relation to health and safety and security of the premises. Documents could not be found when asked. After the inspection a general risk assessment which included a list of control measures was submitted; however, the practice did not have an action plan which clearly identified the improvements needed and those completed. **CQC inspection 26 June 2019**	

At this inspection, we found systems to manage risks had improved. There were comprehensive risk assessments carried out for patients and risk management plans were developed effectively, in line with national guidance.

- We saw a range of risk assessments including, fire, Legionella, health and safety.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Date of last infection prevention and control audit: January 2019	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes

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

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

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)	0.54	0.78	0.91	No comparison available
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)	4.4%	9.3%	8.7%	No comparison available
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)	6.26	6.75	5.60	No comparison available
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)	1.61	1.44	2.13	No comparison available

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	Yes

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were 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.	N/A
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.	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.	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:

Previous CQC inspection 31 October 2018

- At our inspection in October 2018, we found the practice had not always been monitoring patients prescribed high risk medicines appropriately. We found the practice was unable to provide evidence that nine patients, whose records we looked at, were correctly monitored prior to prescribing. Patients were prescribed medicines even though the prescribing clinician did not have the blood results necessary to ensure the prescribed dose was correct. These patients were not monitored according to best practice guidelines from National Institute of Health and Care Excellence (NICE).

- At our inspection in October 2018 we found the practice had no paediatric (child) defibrillator pads and no paediatric pulse oximeter. There were no risk assessments to justify these decisions.

Medicines management	Y/N/Partial

CQC inspection 26 June 2019

- At this inspection we found the practice had taken steps to improve safe use of medicines. The practice had reviewed medicines management with the Bromley CCG pharmacy advisors and, in November 2018, introduced a protocol to monitor high risk drugs. We saw staff followed the protocol for prescribing of high-risk medicines. There was a written policy on warfarin prescribing. When the practice prescribed warfarin, they would ask patients for their book, they would then complete a warfarin template, we saw that bloods were checked every time. The practice had completed a search of all patients taking high risk medicines to ensure patients were correctly being recalled for monitoring. We saw an example of a letter sent to all patients identified on high-risk medicines, advising that patients who were on medication for conditions which required regular biological testing would only be issued medication if they were up to date with their testing. The practice told us they now included messages in the prescription form for both the patient and the pharmacist about having blood tests prior to receiving prescriptions for high-risk medication. We saw also saw a notice in reception explaining that patients who were on medication for conditions which required regular biological testing would only be issued medication if they were up to date with their testing. We looked at nine patients prescribed high risk medicines, all had received regular blood tests.
- The practice had obtained paediatric defibrillator pads, and these were stored with the defibrillator. At our inspection in October 2018 there was no paediatric pulse oximeter. At this inspection we saw that the practice had obtained a paediatric pulse oximeter.

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: Two	Yes
Number of events that required action: Two	Yes

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

Event	Specific action taken
Overnight Windows update failure leaving Windows operation system and the EMIS web system inoperable	Print the patient appointment list for the next day the previous evening. Robust recording of computer failures so that it can be addressed by CCG/ nationally. Discussed at team meeting.
Patient was verbally abusive and aggressive at the counter towards the reception staff	Staff made aware to alert other staff members. Staff made aware to use the panic alarm button when exposed to abusive/violent patients especially when they are in the surgery alone until the other staff member arrives. Discussed at team meeting.

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

Explanation of any answers and additional evidence:

Previous CQC inspection 31 October 2018

- At our inspection in October 2018 the practice had ineffective arrangements for managing safety alerts. Staff, including the GP, were unable to run searches and were unable to efficiently check safety alerts. The practice was not able to respond to alerts promptly. The practice would have to contact the CCG when a search alert came in to the practice and it could take up to 48 hours for a search to be undertaken on behalf of the practice.

CQC inspection 26 June 2019

- At this inspection we found arrangements for managing safety alerts had improved. There was a safety alert policy and staff used a central alert system spreadsheet to record the date of searches and action taken. We saw evidence that each alert was searched within the patient record system and recorded on the spreadsheet. Safety alerts were received by email and checked daily by the practice manager. We asked to see examples of safety alerts. We saw evidence of action in response to the medicine alert in April 2018, on sodium valproate in women of childbearing age. The practice manager told us that safety alerts are distributed to clinical staff. The practice manager told us he printed off copies of the safety alerts and each clinician is given a copy. We saw a folder where paper copies of safety alerts were stored and retained as a surgery record.

Effective Rating: Good

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment were 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

Prescribing	Practice	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)	0.95	0.45	0.79	No comparison available

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.
- Health checks were offered to patients over 75 years of age.
- The practice told us they participated in dementia screening.
- The practice was part of the ICN (Integrated Care Network), which were instigated by the community matron and then individual patients were discussed at MDT meetings via teleconference.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- 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.
- Since the last inspection we saw the practice had activated asthma action plan templates on the electronic patient record system so that action plans could be printed off and given to all patients who had an asthma management plan agreed.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

Diabetes Indicators	Practice		CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	72.8%		75.3%	78.8%	No comparison available
Exception rate (number of exceptions).	2.9%	(4)	9.0%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	92%		75.6%	77.7%	No comparison available
Exception rate (number of exceptions).	1.4%	(2)	9.2%	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)	75%		77.5%	80.1%	No comparison available
Exception rate (number of exceptions).	2.9%	(4)	11.1%	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)	86.3%		73.1%	76.0%	No comparison available
Exception rate (number of exceptions).	2.4%	(3)	8.1%	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)	100%		90.7%	89.7%	No comparison available
Exception rate (number of exceptions).	0	(0)	12.0%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	89.8%	79.9%	82.6%	No comparison available
Exception rate (number of exceptions).	1.3% (4)	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)	76.9%	88.3%	90.0%	No comparison available
Exception rate (number of exceptions).	0% (0)	5.5%	6.7%	N/A

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 percentage of children aged 1 who had completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) were lower, however the practice provided unverified data showing that taking into account those vaccinated later in this group or children, the practice had met the WHO level.
- 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)England)	21	26	80.8%	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)England)	30	33	90.9%	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)England)	31	33	93.9%	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)	31	33	93.9%	Met 90% minimum (no variation)

Any additional evidence or comments

- The practice provided us with unverified data which showed child immunisation uptake rate had improved. The practice informed us they wrote to patients, sent text reminders and called patients to attend.

Child Immunisation	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) (01/04/2018 to 31/01/2019) (Unverified)	95%	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.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- Hub appointments offering appointments up to 8pm during the weekday and weekend appointments were available for patients, as well as extended hours were provided on Wednesdays from 6.30pm to 8pm.

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)	65.6%	73.2%	71.7%	No comparison available
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)	60.0%	74.3%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE)	38.6%	55.4%	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. (PHE)	100.0%	74.9%	71.2%	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)	52.9%	55.8%	51.9%	No comparison available

Explanation of any answers and additional evidence:

- The practice informed us they send reminders out to patients on their prescriptions to inform patients to book appointment with the nurse for a cervical smear from three months prior to their due date. Since October 2018 they have followed Bromley CCGs enhanced service for bowel and breast screening, they text message and send letter invites to engage with cancer programmes.

People whose circumstances make them vulnerable

Population group rating: Good

Findings
• End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. • The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. • The practice 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. • The practice participated in Learning Disabilities health check scheme; proactively inviting this group to extended appointment. • Alerts were put on the system to identify these patients and they would be offered double appointments if required.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

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. • 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. • Dementia care plans lacked detail. When we raised this with the practice they informed us they

would work on this and add more detail to plans.

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)	91.3%	86.8%	89.5%	No comparison available
Exception rate (number of exceptions).	0 (0)	10.3%	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)	91.3%	84.8%	90.0%	No comparison available
Exception rate (number of exceptions).	0 (0)	8.2%	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)	71.4%	80.3%	83.0%	No comparison available
Exception rate (number of exceptions).	0 (0)	4.8%	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)	547	532.2	537.5
Overall QOF exception reporting	3.6%	4.6%	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.	Yes

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

- The practice undertook two full cycle audits, one audit looked at women who developed diabetes during pregnancy (gestational diabetes), who were followed-up with annual reviews in order to diagnose diabetes early and start treatment appropriately. In the first cycle 50% of patients were followed up appropriately. The audit showed that a more vigilant approach in terms of read-coding appropriately and alerting all staff about the importance of following up women with gestational diabetes is important in order to detect early onset diabetes in those patients. In the second cycle 100% of patients were followed up appropriately. The other audit looked at if the practice was following local guidance on vitamin D prescribing in practice. The audit demonstrated the practice had prescribed vitamin D according to our local guidelines in 54% of patients in the first cycle and 98% in the second cycle.

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.	N/A
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: • An induction checklist was in place for newly recruited staff.	

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

For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

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

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)	96.6%	94.4%	95.1%	No comparison available
Exception rate (number of exceptions).	0.6% (3)	0.5%	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: • We saw the practice had a consent policy and saw evidence they were following the policy.	

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

CQC comments cards	
Total comments cards received.	5
Number of CQC comments received which were positive about the service.	4
Number of comments cards received which were mixed about the service.	1
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comment cards	The comment cards received were mostly positive. Patients said they felt staff were caring, friendly and helpful. They said reception staff were polite and helpful. They described examples where they were listened to and treated with respect, dignity and kindness, other comments included that the service provided was excellent and staff were understanding. One comment card that had a mixed point of view was although they thought the service was good, when they were told to expect a call, they never received a call.
Patient interviews and Patient group.	We spoke with one member of the Patient Participation Group who told us the practice worked with and supported patients and their families to achieve the best outcome for patients. We spoke with one member of the Patient Participation Group (PPG). The member told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They felt the practice listened, and the doctors were very caring and supportive and responsive to their needs. The member said the practice always kept them informed of how things were progressing. The member felt the GP went beyond her call of duty, she gave an example of where the GP carried out a case study and checked information offline then got back to her.
Friends and Family Test	The practice had reviewed Friends and Family Test results, results for April and May were:

	April 2019 20 patients were extremely likely to recommend, 5 were likely to recommend. May 2019 23 patients were extremely likely to recommend, 2 were likely to recommend and 1 was neither likely or unlikely.

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
Not available	392	99	25.3%	Not available

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) (GPPS)	72.0%	89.0%	89.0%	No comparison available
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) (GPPS)	72.9%	87.0%	87.4%	No comparison available
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) (GPPS)	90.9%	94.9%	95.6%	No comparison available
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) (GPPS)	71.9%	84.3%	83.8%	No comparison available

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

Any additional evidence
Previous CQC inspection 31 October 2018 • At our inspection in October 2018 the practice was not aware of the national GP patient survey, and had not undertaken any surveys of its own. **CQC inspection 26 June 2019** • At this inspection the practice showed us evidence that they had reviewed the National patient survey and devised an action plan to address areas where they were below the local and national average. They also compared their results against other local practices. The practice had carried out their own patient survey in February 2019, they confirmed questionnaires were handed out randomly to patients and they were also left at the front of reception desk over a week's period. A total of 30 response were received and analysed: Comments from the survey included: that the GPs made patients feel relaxed and checked patients understood what they were discussing; were thorough, polite, professional and cared about the health and well being of patients; and were very helpful and efficient. We also reviewed the most recent GP patient survey data that came out shortly after the inspection many answers were above or comparable to local and national averages.

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

Source	Feedback
Comment cards and Interview with PPG member.	Patients were positive about the involvement they had in their care and treatment. They said the GPs explained their condition and treatment and they were involved in decisions about their treatment.

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) (GPPS)	87.4%	93.8%	93.5%	No comparison available

	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.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	• The practice had identified 1.2% (32) of their patient list as carers
How the practice supported carers.	• The practice provided carers with support information and guidance, information was displayed in the waiting room and staff would signpost carers to relevant support groups and agencies, carers were encouraged to contact Bromley Well. • Carers were offered the flu jab.
How the practice supported recently bereaved patients.	• Keep checking on them, offer appointments if required.

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

Responsive Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	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	8.00am - 6.30pm
Tuesday	8.00am - 6.30pm
Wednesday	8.00am – 8.00pm
Thursday	8.00am - 6.30pm
Friday	8.00am - 6.30pm
Appointments available:	
Monday	9.00am-12.00pm / 4.00pm-6.00pm
Tuesday	9.00am-12.00pm / 4.00pm-6.00pm
Wednesday	9.00am-12.00pm / 4.00pm-8.00pm
Thursday	9.00am-12pm
Friday	9.00am-12.00pm / 4.00pm-6.00pm
Extended hours opening	Wednesday 6:30pm – 8:00pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
Not available	392	99	25.3%	Not available

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) (GPPS)	93.0%	95.1%	94.8%	No comparison available

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.
- There was a medicines delivery service for housebound patients.

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
• Additional nurse appointments were available until 7pm on a Wednesday for school age children so that they did not need to miss school. • We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this. • All parents or guardians calling with concerns about a child were offered a same day appointment when necessary. • Parents with concerns regarding children under the age of 10 could attend a drop-in clinic held at the same time as the twice weekly baby clinic.

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. • Extended hours were available from 6:30pm-8:00pm every Wednesday. • Hub appointments offering appointments up to 8pm during the weekday and weekend appointments were available for patients.

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 absolutely 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 (to) (GPPS)	68.2%	N/A	70.3%	No comparison available
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) (GPPS)	68.1%	70.5%	68.6%	No comparison available
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) (GPPS)	57.9%	65.5%	65.9%	No comparison available
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) (GPPS)	77.8%	74.5%	74.4%	No comparison available

Source	Feedback
For example, patients spoken to	• Patients that we spoke to on the day of the inspection, said they could usually get an appointment, one patient commented that it does take a long time to get through on the phone.

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.	2
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
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:

Previous CQC inspection 31 October 2018

- At our inspection in October 2018 the practice was unable to fully examine complaints as the practice could not show us any of the complaints they had received as we were told these could not be found.

CQC inspection 26 June 2019

At this inspection the practice was able to show us two complaints that had been responded to in a timely way. The practice was also able to show us a record of all verbal complaints logged and was now able to analyse trends.

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient was unhappy about waiting times. Dr was unable to fill a private form as this information was not disclosed to reception when the appointment was booked.	Discussed during practice meeting. Reception were informed to be more informative and tell patients that letters and forms will not be filled out during patient appointments when booking 'private issues' appointments Informed patient of action taken by letter.
Not seen as running late, waiting times and surgery procedures.	Discussed during practice meeting, additional signs stating appointments are for 10minutes only have been placed in reception. When patients call, reception remind them to arrive on time. Reception to give more information to patients when they call and express that they need to arrive on time, despite the late running of the surgery.

Well-led Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders could demonstrate that 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 told us that leaders in the practice involved them in decisions, and all staff in the practice were clear about their roles and the policies and procedures which guided the way they worked.	

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

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: • Staff spoken to said leaders were approachable and listened if they raised concerns. • The provider was aware of and systems to ensure compliance with the requirements of the duty of candour.	

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

Source	Feedback
Staff	Staff told us that they felt the culture of the practice was positive. They told us the manager and GP were available and were supportive.

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: **Previous CQC inspection 31 October 2018** • Systems and processes were not fully established and did not operate effectively. There was a lack of oversight of significant events, patient feedback and complaints. There was a lack of formal governance structure in place to ensure priority areas of improvement were highlighted,	

risks identified, and actions planned. A number of documents could not be found on the day of the inspection including risk assessments, significant events records, and complaints.

- Leaders did not have a clear understanding of computer systems used to manage and monitor patients. No risk assessment had been undertaken to acknowledge the impact or risk this posed to patients.
- The practice did not have an effective system in place to monitor patients on high risk medicines
- The system for managing safety alerts was ineffective. We were told by the practice manager it could take up to 48 hours to process as the CCG needed to be contacted to carry out searches on the patient recording system.
- There was no oversight for managing tasks sent to the administrator through the document managing system. On the day of the inspection we noted 175 tasks had been sent to the administrator dating back to September 2018, none of these had been completed, 10 had been actioned.
- There were no written protocols for staff dealing with letters that came into the practice, though all staff we spoke with knew what the process was. Practice leaders had established some policies, procedures and activities to ensure safety, but there was a lack of oversight and they could not assure themselves that they were operating as intended.
- At the previous inspection, the provider had not ensured all appropriate staff had had a DBS check.

CQC inspection 26 June 2019

At this inspection:

- We saw that systems and process were fully established and operated effectively. We saw there were formal processes for recording significant events, we saw that events were discussed in meetings. Staff were able to find records of significant events easily events.
- We saw the complaints policy had been reviewed and updated, we saw that complaints were now included as standard agenda item at meetings and were discussed. The practice was now recording all verbal complaints and kept a log book.
- There were improvements in the use of the computer system to support the delivery of safe care and treatment. The practice told us they had engaged with the CCG and had arranged training on the patient record and had looked at other practices locally who used the same system
- At this inspection we found suitable systems in operation to monitor patients on high risk medicines.
- We saw there were suitable systems to manage safety alerts. For example, safety alerts were checked daily by staff and documented on a central alert spreadsheet and the appropriate action was taken and recorded.
- At this inspection we looked at the system for managing tasks these were now suitable managed. There were written protocols for staff dealing with letters that came into the practice. Staff we spoke with knew what the process was. Practice leaders had established document handling procedures and activities to ensure safety.
- There was a system to ensure Disclosure and barring service (DBS) checks in place for appropriate staff. We checked five staff records all had DBS checks the practice manager now had an enhanced DBS.
- Dementia care plans lacked detail, they were just coded. When we raised this with the practice

they informed us they would work on this and add more details to plans

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.	Yes
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:

Previous CQC inspection 31 October 2018

- At our previous inspection there were unclear and ineffective processes for managing risks, issues and performance. Practice leaders said they had oversight of safety alerts, serious events and complaints, however the system used to manage these was not effective. The leaders were unable to run searches on the system and relied upon the CCG's support for this, which could take up to 48 hours. We were told complaints and significant events records could not be found.
- There were ineffective processes to identify, understand, monitor and address current and future risks including risks to patient safety. For example, there was no oversight for not having a paediatric pulse oximeter, or child defibrillator pads and risk assessments had not been undertaken for not having these.
- The practice did not have an effective system in place to monitor patients on high risk medicines.

CQC inspection 26 June 2019

- At this inspection we found processes for managing risks, issues and performance had improved. Leaders demonstrated there were effective process to identify, understand, monitor and address current and future risks including risks to patient safety for example; the system to manage safety alerts had improved.

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

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: • Staff feedback highlighted a strong team with a positive supporting ethos.	

Feedback from Patient Participation Group.

Feedback
• The practice worked closely with the Patient Participation Group (PPG). The PPG reported that the practice was very receptive to their suggestions, they told us the practice always listened and would make changes if they could.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: • At this inspection we looked at asthma review records. Since our previous inspection, the provider had worked with Bromley Healthcare IT support and activated the asthma action plan template on the new electronic patient record system. • We saw the practice had developed meeting agendas and now included Significant events and complaints as a standard agenda item.	

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.