Care Quality Commission

Inspection Evidence Table

Dr P Arumugaraasah's & Partners (1-574806176)

Inspection date: 9 July 2019

Date of data download: 19 July 2019

Overall rating: Good

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

Safe Rating: Good

- All necessary recruitment checks including references had been undertaken for staff.
- Staff who carried out chaperoning had received training and were aware of their responsibilities.
- There was evidence of lessons learned and improvements made when things went wrong.

Safety systems and processes

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

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

Safeguarding	Y/N/Partial
Explanation of any answers and additional evidence: • The partner GPs were the adult and children safeguarding leads. • All staff underwent annual safeguarding training and the safeguarding leads facilitated regular updates. • Safeguarding was a standing agenda item at clinical team meetings. • The practice had regular liaison with the local health visitor who on occasion attended practice meetings.	

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

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: 04/07/2018	Y
There was a record of equipment calibration. Date of last calibration: 11/2018	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 09/2018	Y
There was a log of fire drills. Date of last drill: 04/07/2019	Y
There was a record of fire alarm checks. Date of last check: 06/05/2019	Y
There was a record of fire training for staff. Date of last training: 18/05/2019	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 10/07/2018	Y
Actions from fire risk assessment were identified and completed.	N/A

Explanation of any answers and additional evidence:

- The practice had three members of staff identified as fire marshals to accommodate staff leave. Staff were aware of the identity of the fire marshals.
- The provider was able to provide assurance that the fire alarm had been checked in 2018. The building management had carried out a fire risk assessment. No issues had been identified.

Additional assessments carried out at the practice included:

- Emergency lighting 05/04/2019
- Electrical installation condition report: 17/02/2017
- Reviewed cleaning audit carried on 8 July 2019
- Window restrictors risk assessment: 17/04/2019
- Boiler maintenance record: 14/12/2018
- Legionella testing – 23/05/2018
- Water hygiene: 15/05/2019

- Disinfection certificate – 29/9/18
- Gas Safety: 14/12/2018

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 17/04/2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 17/04/2019	Y
Explanation of any answers and additional evidence: • Health and Safety compliance report showed that the practice had met all requirements.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 03/01/2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	N/A[1]
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers: 1. There were no issues identified in the infection control audit.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence: • Clinicians had received training on sepsis to improve their ability to identify symptoms and act appropriately where they had concerns. There was a sepsis poster at reception which outlined symptoms and action to take and reception staff were aware of the poster. • The practice had processes in place to cover absences.	

- All requests for home visits were triaged by the duty GP.
- There were public awareness posters in waiting area and on the screen.

Information to deliver safe care and treatment

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

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

Explanation of any answers and additional evidence:

- The practice had demonstrated improvement and acted on patient correspondence and pathology results in a timely manner.
- Test results and referrals were managed and checked on a regular basis to ensure all were appropriate. Any abnormal or concerning test results were actioned by one of the clinicians in a timely manner.

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) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA)	0.51	0.57	0.88	Significant Variation (positive)
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). (01/04/2018 to 31/03/2019) (NHSBSA)	3.8%	7.0%	8.7%	Variation (positive)
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 (01/10/2018 to 31/03/2019) (NHSBSA)	5.97	5.18	5.61	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA)	2.86	1.50	2.07	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about	Y

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.	Y[1]
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y[2]
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:

1. In relation to the monitoring of high-risk medicines, the practice ensured that an appropriate blood test result was present before a prescription could be issued.
2. The practice had all but one of the emergency medicines required. The leadership team had decided not to stock medicine for croup and had put in place a risk assessment outlining what action would be taken if a patient attended the practice with the condition.

   Medicines that required refrigeration were stored and monitored appropriately.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	3
Number of events that required action:	3
Explanation of any answers and additional evidence: • Staff said when things went wrong at the practice there was a culture of openness and support. • Significant events were a standing agenda item at staff meetings, the minutes of meetings were circulated to all staff and saved on the practice's computer drive.	

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

Event	Specific action taken
Childhood immunisation data submission failure	• All data submission must be done and cross checked by the practice nurse and practice manager or two members of staff, instead of one, only at the time of submission. • Practice nurse, practice manager and clinical governance lead to undergo refresher Open Exeter training. • Quarterly submission of immunisation data on Open Exeter to be done timely under the supervision of the practice manager. • A log of immunisation data submission to be kept by the practice manager.
Referral not sent via email	• Letter of apology explaining technical failure sent to patient. • Practice administrator informed to immediately raise any concerns/anomalies with the practice manager. • Practice begun maintaining a spreadsheet to track normal referrals. • Contacted EMIS Health and Primary Care Support England.

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

Explanation of any answers and additional evidence:

- There was an effective system in place to receive and share all safety alerts. If action was required, this was assigned to an appropriate member of staff and it was recorded when this action complete.
- Staff we spoke to demonstrated good knowledge of recent medicine safety alerts and told us what action had been taken.
- We saw examples of actions taken on recent alerts for example, regarding sodium valproate.

Effective Rating: Good

- At the last inspection we rated the practice requires improvement for providing effective care because we found that outcomes for patients with diabetes at the practice were lower than the CCG and national average. The practice is now rated good for providing effective care due to improvements made.
- Quality improvement activity demonstrated improved for patients.
- Improved performance in diabetes and cervical cancer indicators.
- Staff were appropriately trained to carry out their duties effectively.
- The practice provided their unverified 2018/19 QOF performance data for some indicators (outlined below). Although the data has not yet been verified by NHS Digital it demonstrates how the practice progressed towards target and shows a difference from the previous year due to improvements within the practice.

As these are non-verified results at this stage there are no comparators to national or local averages.

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.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) (NHSBSA)	0.20	0.36	0.77	Significant Variation (positive)

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.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The practice had quarterly a multidisciplinary meeting with palliative care nurses.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions Population group rating: Good

Findings

- Patients with long-term conditions were offered 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 shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	61.7%	74.8%	78.8%	Variation (negative)
Exception rate (number of exceptions).	5.3% (23)	7.6%	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)	62.3%	76.7%	77.7%	Variation (negative)
Exception rate (number of exceptions).	5.7% (25)	6.9%	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)	69.9%	81.9%	80.1%	Tending towards variation (negative)
Exception rate (number of exceptions).	7.1% (31)	8.0%	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)	79.5%	76.1%	76.0%	No statistical variation
Exception rate (number of exceptions).	0.5% (1)	2.1%	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)	93.2%	91.3%	89.7%	No statistical variation
Exception rate (number of exceptions).	6.4% (3)	5.7%	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)	74.2%	81.4%	82.6%	Variation (negative)
Exception rate (number of exceptions).	4.0% (30)	3.3%	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)	91.7%	89.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	7.7% (2)	6.3%	6.7%	N/A

Any additional evidence or comments

The practice's unverified QOF performance data for 2018/19:

- In 2018/19 QOF, the practice achieved 81.5 points out of 86 points for diabetes indicators, which equates to 95%. There were improvements made in several indicators.
  In particular:
    - 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 – the practice achieved 77%, this was an improvement on the previous year when they achieved 62%. Exception rate: 16%
    - 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 – the practice achieved 90% which was an improvement on the previous year when the practice achieved 62%. Exception rate: 15%
    - 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) – the practice achieved 90% which was an improvement on the previous year when the achieved 70%. Exception rate: 14%
    - 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 achieved 85%, this was an improvement on the previous year and above the QOF performance target which is set at 80%. Exception rate: 9%
    - The practice achieved 100% for 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.
    - The practice achieved 100% for the percentage of patients with COPD who 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.

- In response to our query about the practice's high exception reporting rate, they explained that they:
    - Have an unusually young working migrant and mobile population often poorly compliant with long term condition monitoring due to their work schedule. Patients frequently changed

address and telephone phone numbers making contacting then challenging. .
    - Have a majority ethnic population, a good proportion have long term conditions and spend long periods abroad in their home countries, making keeping appointments for long-term condition management difficult.
    - Find that cultural, health and religious beliefs influence a high number of their patients resulting in denial of their long-term conditions and failure to keep monitoring appointments, opting for informed decent.

- The practice's diabetes lead offered a weekly diabetes clinic in conjunction with the practice nurse. The practice also hired a locum diabetes specialist nurse practitioner to carry out an additional clinic for patients.
- In 2018/19, the practice completed 82%, of the 8-care process (A series of annual checks to monitor and improve the health of people with diabetes which are among measures proposed by NICE for its Quality and Outcomes Framework), which was a 66.6% increase on the previous financial year.
- For 2018/19 the practice became 5th best practice within the CCG area for managing diabetes.

Families, children and young people Population group rating: Good

Findings

- The practice provided an in-house baby clinic and weekly immunisation clinic. Childhood immunisation uptake rates in 2018/19 were below the World Health Organisation (WHO) targets.

  Below is the practice's 2018/19 Childhood immunisation performance data which was an improvement on their 2017/18 performance:

    - 83% - aged 1
    - 86% - Aged 2 (booster immunisation for Pneumococcal infection)
    - 87% - aged 2 (MenC)
    - 87% - aged 2 (one dose of MMR)
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- 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.
- 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.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
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)	68	76	89.5%	Below 90% minimum
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)	48	55	87.3%	Below 90% minimum
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)	47	55	85.5%	Below 90% minimum
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)	48	55	87.3%	Below 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information:
https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

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

Findings

- Extended opening hours were available on Monday between 7am and 8am and on Wednesday and Thursday between 6:30pm and 7:30pm.
- 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.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	67.3%	66.0%	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)**	56.7%	60.8%	69.9%	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)**	34.8%	40.5%	54.4%	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)**	91.7%	73.1%	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)	55.0%	53.6%	51.9%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- 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 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: 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. • Same day and longer appointments were offered when required. • There was a system for following up patients who failed to attend for administration of long-term medication. • When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. • Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. • All staff had received dementia training in the last 12 months. • Patients with poor mental health, including dementia, were referred to appropriate services. • The practice participated in shared care with the community mental health team, and at times took over the responsibility of carrying out depo injections for stable patients.

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)	91.4%	92.2%	89.5%	No statistical variation
Exception rate (number of exceptions).	6.7% (5)	7.4%	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)	92.8%	91.9%	90.0%	No statistical variation
Exception rate (number of exceptions).	8.0% (6)	7.4%	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%	82.5%	83.0%	No statistical variation
Exception rate (number of exceptions).	14.3% (2)	5.2%	6.6%	N/A

Any additional evidence or comments
Below is the practice's unverified 2018/19 QOF performance in three mental health indicators: • 95% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months. • 97% of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded in the preceding 12 months. • 73% of patients diagnosed with dementia had their care plan reviewed face-to-face in the preceding 12 months. This was below the practice's previous performance (75%) but above the QOF target of 70%.

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)	525.3	539.2	537.5
Overall QOF score (as a percentage of maximum)	94.0%	96.5%	96.2%
Overall QOF exception reporting (all domains)	6.3%	4.4%	5.8%

Any additional evidence or comments
For 2018/19 the practice achieved 554.5 out of a maximum of 559 QOF performance points and received a letter of commendation for their local CCG for improvements made in diabetes care.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

The practice undertook a range of audits and quality improvement activity within the last 12 months including:

- Calcium and Vitamin D3 therapy review.
- Review of two week wait referrals to check their appropriateness.
- In response to the practice's 2017/18 QOF performance for the control of diabetic patient's blood pressure, an audit was carried out to review their diabetes management. The audit showed that as of March 2018 the practice had 436 patients over 17 years old on the practice's diabetic register out of which 256 patients, equating to 62% had a blood pressure reading of 140/80mmHg or less. This was below the set standard of 78%. Consequently, the practice put the following action plan in place:
    - Generated a list patient within the cohort and developed a recall programme for these patients to attend the practice's weekly diabetic clinic.
    - An alert system was installed on the practice's computer system which enables a patient's triple therapy and the 8 care processes score to pop-up when a diabetic patient's record is opened, to inform the GP and facilitate optimum management of their condition.

  In December 2018, the practice conducted a second audit, this showed that out of 465 over 17-year olds on the practice's diabetic register, 310 had achieved a blood pressure reading of 140/80mmHg or less equating to 71%. At the end of the year the practice had surpassed the target with 90% achievement.
- The practice carried out an audit of patients with COPD without asthma, who were prescribed an inhaler, with a view of the patients adopting usage of a new inhaler containing a medicine found to be more effective in the treatment of their condition and lower in cost. In June 2019, a baseline audit showed that 64% of the relevant patients were being prescribed the previous inhaler. These patients were invited to the practice to discuss the advantages of the device over the previous one and were advised to switch. A re-audit was carried out in July 2019 and found that the practice had reached the 100% standard set out in the NICE guidelines.

- In 2016 the practice carried out an audit of pre-diabetic patients to ensure they were correctly identified and referred to diabetic services to reduce their risk of developing type II diabetes. A search identified 62 patients as having an Hba1c between 42 and 47mmol/mol; one of those patients identified had left the practice. Of the remaining 61 patients, 16 had previously been referred to a diabetes prevention programme, representing 26%, which was below the practice's standard of 50% for high-risk patients. In response to the findings the practice:

    - Contacted the remaining 45 patients and referred them to the relevant service.
    - Invited a member of a local diabetes programme to the practice's team meeting to discuss and educate team members about pre-diabetes and what the programme entails.
    - Practice administrators were reminded that all referral forms should be uploaded to patient notes.
    - Clinicians were advised to correctly read-code patients that have been referred to the diabetes programme in the appropriate section of consultation notes.

    A second cycle of the audit was carried out between April 2018 and March 2019. This showed that 73% of patients whose Hba1c was 42 and 47mmol/mol had been referred to a diabetes programme. Arrangements were put in place to refer the remaining patients.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y[1]
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.	Y[2]
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: 1. The practice had a comprehensive induction programme in place for new staff. This included, staff training, confidentiality agreement and building requirements. 2. All staff had undergone an appraisal within the last 12 months.	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y

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

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	95.4%	94.5%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.5% (5)	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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y

Caring Rating: Good

- The practice was previously rated requires improvement for caring due their results in the 2017 GP Patient survey. At this inspection they were rated good due to improvements made.
- Thirty-three CQC comment cards received, 26 were wholly positive about the care and treatment received at the practice.
- We observed staff treating patients with respect and patients interviewed confirmed this.

Kindness, respect and compassion

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

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

CQC comments cards	
Total comments cards received.	32
Number of CQC comments received which were positive about the service.	26
Number of comments cards received which were mixed about the service.	5
Number of CQC comments received which were negative about the service.	1

Source	Feedback
Patient interview	The patient we spoke with was pleased with the treatment received at the practice and spoke of the willingness of staff to assist.
CQC comment cards	Positive – Clinical and reception staff were described a treating people with respect and dignity. Mixed – Positive about care and treatment but have trouble getting an appointment. Negative – Difficulty with ordering repeat prescriptions.
NHS choices	3 out of 5 stars based on 17 ratings. Since the last inspection, 12 comments were posted. Six were positive about the care and treatment provided, the remaining six commented on difficulty making an appointment and getting through to the practice via the telephone.

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
5252	465	66	14.2%	1.26%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	89.5%	87.0%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	93.4%	83.6%	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 (01/01/2019 to 31/03/2019)	100.0%	94.2%	95.5%	Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	92.8%	79.3%	82.9%	No statistical variation

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

Any additional evidence
Findings from the practice's 2018 patient survey: • More than 50% of the patients are not aware of the surgery's extended hours clinic • More than 56% patients are unaware of surgery's pre-bookable appointments up to 4 weeks in advance and 'did not attend' rates. • 73% patients don't know about the telephone consultations • 81% of patients haven't used telephone consultations • Nearly 30% of the patients wait more than 10 mins to see the clinicians These findings were discussed with the practice's patient participation group and an action plan was put in place. Actions included: • Purchase of a large screen television for the reception area, to advertise services. • Reception staff will promote GP telephone consultations, for those patients whose conditions do not need to be seen physically, i.e. blood test results, referrals chase-up etc. • Recruiting an additional reception staff member.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y[1]
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: 1. Communication aids and easy read materials were available.	

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 (01/01/2019 to 31/03/2019)	90.6%	90.8%	93.4%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: There was a range of information available for patients in the waiting area. To name a few: • Diabetes services • Talking Therapies • Bereavement services	

Carers	Narrative
Percentage and number of carers identified.	72 (1.4%)
How the practice supported carers (including young carers).	The practice had a carer's pack which contained information on national and local support groups.
How the practice supported recently bereaved patients.	The practice maintained a death register and got in touch with patients that were bereaved to offer support and signpost to bereavement services.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

	Y/N/Partial
Patients were informed, and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y

Responsive Rating: Good

- The practice had reviewed the needs of the population and responded accordingly.
- Feedback from patients led to a new telephone system, and complaints were responded to appropriately and within the practice's timeframe.
- Shared care agreements were in place to ensure patient treatment was coordinated.

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am to 6:30pm
Tuesday	8am to 6:30pm
Wednesday	8am to 6:30pm
Thursday	8am to 6:30pm
Friday	8am to 6:30pm
Appointments available:	
Monday	7am-8am 8am-12pm 3pm-6:30pm
Tuesday	8am-12pm 3pm-6:30pm
Wednesday	8am-12pm 3pm-6:30pm 6:30pm-7:30pm
Thursday	8am-12pm 3pm-6:30pm 6:30pm-7:30pm
Friday	8am-12pm 3pm-6:30pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5252	465	66	14.2%	1.26%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	95.3%	93.7%	94.5%	No statistical variation

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.
- The practice provided effective care coordination to enable older patients to access appropriate services.

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

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- 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 7:30pm on a Monday for immunisations and cervical cytology tests.
- 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 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.
- The practice was open until 7:30pm on a Wednesday and Thursday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available Saturday and Sunday, via a locally based out of hours provider.

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 such as homeless people and travellers. • The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services. • 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.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y

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 (01/01/2019 to 31/03/2019)	90.0%	N/A	68.3%	Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	76.1%	60.2%	67.4%	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 (01/01/2019 to 31/03/2019)	79.2%	60.2%	64.7%	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 (01/01/2019 to 31/03/2019)	75.3%	65.4%	73.6%	No statistical variation

Any additional evidence or comments
• The practice actively worked towards tackling high ‘did not attend’ rates and created a “Don’t be a DNA” poster with their patient participation group. • Practice installed a new telephone answering system, that informs patients where they are in the telephone queue.

Source	Feedback
NHS Choices	The practice was rated 3.5 out of 5 stars for appointments. Comments included, a patient commending the practice for always working around their difficult work rota to provide an appointment.

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.	8
Number of complaints we examined.	8
Number of complaints we examined that were satisfactorily handled in a timely way.	8
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Complaint	Specific action taken
Prescription management	• Interviewing of practice administrative staff. • Audit of patient record system. • Introduced a system for patients to complete a consent form of nomination. • Letter written to patient outlining the incident and action taken.
Patient felt referral was to incorrect department	• Letter sent to patient outlining the reason for referral.

Well-led Rating: Good

- The practice was rated requires improvement at their 2018 inspection due to feedback from patients and because the management of patients with diabetes had not been adequately addressed since their inspection in 2017.The practice is now rated good for providing a well-led service due to improvements made in both areas. In addition:
- Governance of the practice assured the delivery of high-quality and person-centred care, supported learning and innovation, and promoted an open and fair culture.
- Staff understood the practice's vision, values and strategy, and their role in achieving them.
- Arrangements with partners and third-party providers were governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care.

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.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y

Explanation of any answers and additional evidence:

- A clear leadership structure was in place. The partners at the practice demonstrated a commitment to driving improvement in the quality of care and patient experience. We were told there was an open and transparent culture at the practice and all staff were engaged in the direction of the practice.
- Staff were encouraged to participate and feedback through practice meetings or direct to the managers or one of the GPs.
- Partners were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. There was evidence that future changes and requirements were acted on immediately or a plan put in place in readiness for changes. For example, the change of coding on the electronic patient record system.
- The practice held clinical meetings, palliative care meetings all staff meetings, reception meetings, complaints meetings and PPG meetings.
- We saw that all meetings were appropriately minuted and actions were logged.

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y_1
Progress against delivery of the strategy was monitored.	Y

Explanation of any answers and additional evidence:

1. The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population. They demonstrated a determined attitude to overcome the barriers the practice and the population faced.

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y[1]
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y[2]
The practice encouraged candour, openness and honesty.	Y[3]
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y

Explanation of any answers and additional evidence:

1. Staff spoken to said leaders were approachable and listened if they raised concerns. They felt respected, supported and valued.
2. Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
3. Staff reported there was an open-door policy, and they could contact managers and GPs whenever they had a concern.

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

Source	Feedback
Staff interviews	• Staff told us that they were well supported by management at the practice and they felt able to approach managers for support. • Staff we spoke with told us that the whole practice worked as a team and that all the GPs and management were very approachable. Staff told us they found there was a supportive environment both clinically and non-clinically. • Staff said they felt confident that managers would address their concerns and issues raised.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y_1
Staff were clear about their roles and responsibilities.	Y_2
There were appropriate governance arrangements with third parties.	Y

Explanation of any answers and additional evidence:

1. Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care. Staff were clear on their roles and accountabilities.

2. There were named clinical and non-clinical leads. Namely:

    - Safeguarding adults and children
    - Complaints lead
    - Infection control

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y_1
There was a systematic programme of clinical and internal audit.	Y_2
There were effective arrangements for identifying, managing and mitigating risks.	Y_3
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: 1. The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. 2. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. 3. Practice partners reviewed all MHRA alerts, incidents, and complaints.	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y_1
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers: 1. The practice had a patient participation group with 30 members who met quarterly. Meeting minutes and the date of the next meeting were advertised on the practice's website.	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y[1]
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: 1. There was clear evidence that staff at the practice drove continuous improvement using a wide range of information as well as their own knowledge and skills. The practice was passionate about ensuring they always provided their patients with the best care possible. For example, the practice closely monitored the effectiveness of their diabetes treatment through carrying out regular audits, employing a diabetes specialist nurse and implementing a weekly diabetic clinic.	

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.