# Care Quality Commission

## Inspection Evidence Table

## Tuxford Medical Centre (1-543702973)

**Inspection date: 12 July 2019**

**Date of data download: 03 July 2019**

## Overall rating: Good

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

## Effective                                    Rating: Good

**Effective needs assessment, care and treatment**

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

|  | Y/N/Partial |
|---|---|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | Y* |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Y |
| 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 |
| Explanation of any answers and additional evidence: <ul><li>*Templates had been developed within the electronic patient record system to support clinical staff and promote consistency.</li><li>*The practice had a well-developed schedule of meetings including monthly clinical meetings where guidance was shared and discussed.</li><li>*New guidance was added to the practice electronic information management system which was accessible to all staff.</li></ul> | |

| 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) | 0.28 | 0.58 | 0.77 | 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.

- 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. Data provided by the practice showed they were high achievers in this area compared to other local services.

## People with long-term conditions          Population group rating: Outstanding

### Findings

- Data showed the practice was performing above CCG and national averages for the care and treatment of the majority of long-term conditions.

- 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.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.
- The practice had commenced a leg ulcer service offering wound care, compression bandaging and Doppler tests in the practice. The practice nurses had received specific training for this service and had a developed a template to ensure a consistent assessment process. The practice had 17 patients on a maintenance treatment list whose leg ulcers had healed and one patient who required ongoing care. The patients were seen, as and when required, in an extended appointment of up to an hour depending on treatment required.
- A practice nurse and one of the GP partners had a special interest in diabetes and had undertaken specific training in this area. Patients had an annual review with both the nurse and GP.

| 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) | 89.4% | 85.6% | 78.8% | Tending towards variation (positive) |
| Exception rate (number of exceptions). | 13.6% (49) | 14.1% | 13.2% | N/A |
| The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF) | 86.8% | 81.0% | 77.7% | No statistical variation |
| Exception rate (number of exceptions). | 5.0% (18) | 13.6% | 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) | 87.3% | 83.6% | 80.1% | Tending towards variation (positive) |
| Exception rate (number of exceptions). | 9.7% (35) | 20.9% | 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) | 82.7% | 79.6% | 76.0% | No statistical variation |
| Exception rate (number of exceptions). | 5.7% (13) | 24.4% | 7.7% | N/A |

| | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| 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) | 90.5% | 94.1% | 89.7% | No statistical variation |
| Exception rate (number of exceptions). | 2.5% (3) | 20.1% | 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) | 89.2% | 82.8% | 82.6% | Tending towards variation (positive) |
| Exception rate (number of exceptions). | 0.9% (7) | 4.1% | 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) | 99.1% | 92.5% | 90.0% | Variation (positive) |
| Exception rate (number of exceptions). | 6.9% (8) | 5.3% | 6.7% | N/A |

## Families, children and young people        Population group rating: Good

| Findings |
|---|
| <ul><li>Data indicated childhood immunisation uptake rates exceeded the World Health Organisation (WHO) based target of 95% in one of four areas and exceeded the minimum target of 90% in the three other areas.</li><li>The practice contacted the parents or guardians of children due to have childhood immunisations.</li><li>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.</li><li>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.</li><li>Young people could access services for sexual health and contraception. One of the recently recruited practice nurses had extensive experience and specialist skills in contraception and sexual health and was aiming to expand services for young people.</li><li>Staff had the appropriate skills and training to carry out reviews for this population group.</li></ul> |

| 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), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England) | 41 | 44 | 93.2% | Met 90% minimum |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England) | 44 | 45 | 97.8% | Met 95% WHO based target |
| 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) (01/04/2018 to 31/03/2019) (NHS England) | 42 | 45 | 93.3% | Met 90% minimum |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England) | 42 | 45 | 93.3% | Met 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**

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. The practice had identified they had not performed as well as they would like in this area and told us only 31% of eligible patients received health checks. They told us this was due to previous lack of space and capacity. They had recently extended the building and increased the nursing team and were aiming to significantly improve performance in this area.

- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

- The new appointment system included an e-consult system where the patients could email a query to their preferred GP at any time, 24 hours per day. The GP would then respond by email or telephone during practice opening hours depending on the patient's preference and/or query. For example, if the GP felt the patient needed to be seen face to face they would contact them directly

to make an appointment with them and the appointment would usually be on the same day. Patients told us this was a very effective system enabling them to raise queries easily. For example, queries regards medicines without the need for an appointment. Two patients told us how they had emailed the practice with a health concern and had been contacted within the hour and seen the same day.

- The practice had developed a new practice website which offered more interactive services. This enabled patients to easily access a wide range health information and complete health assessments and information for reviews on line.

- There were effective recall systems in place and the practice had high cervical cancer screening rates.

| 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) | 82.2% | 75.7% | 71.7% | Variation (positive) |
| Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE) | 74.8% | 74.3% | 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) | 64.0% | 54.7% | 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) | 69.6% | 72.3% | 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) | 47.1% | 43.4% | 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. The practice provided an audit which had looked at the service provided for patients with a learning disability. They had worked to improve the annual review system and data showed they had increased this provision from 8% in 2014/15 to 93% in 2017/18. Patients were seen in an extended GP and nurse appointment which included a review of medicines, mental health, vaccination status and development of an action plan.

- End of life care was delivered in a coordinated way which considered 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.

- The practice demonstrated that they had a system to identify people who misused substances.

- The practice reviewed young patients at local residential homes.

## People experiencing poor mental health (including people with dementia)

### Population group rating: 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.

- Patients with poor mental health, including dementia, were referred to appropriate services.

| Mental Health Indicators | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF) | 100.0% | 94.1% | 89.5% | Variation (positive) |
| Exception rate (number of exceptions). | 27.8% (5) | 43.6% | 12.7% | N/A |
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF) | 100.0% | 96.0% | 90.0% | Tending towards variation (positive) |
| Exception rate (number of exceptions). | 27.8% (5) | 32.1% | 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) | 90.0% | 83.5% | 83.0% | No statistical variation |
| Exception rate (number of exceptions). | 2.4% (1) | 7.1% | 6.6% | N/A |

**Any additional evidence or comments**

A dedicated member of staff was responsible for contacting patients and offering them a review appointment recalls for reviews in a variety of ways including text messaging, reminders on dispensed medicines, phone calls and letters. We were told patients were only exception rated after at least three attempts had been made to contact them.

**Monitoring care and treatment**

**The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.**

| Indicator | Practice | CCG average | England average |
|---|---|---|---|
| Overall QOF score (out of maximum 559) | 549.0 | 497.1 | 537.5 |
| Overall QOF score (as a percentage of maximum) | 98.2% | 88.9% | 96.2% |
| Overall QOF exception reporting (all domains) | 4.4% | 6.4% | 5.8% |

| | Y/N/Partial |
|---|---|
| Clinicians took part in national and local quality improvement initiatives. | Y |
| The practice had a comprehensive programme of quality improvement and used | Y |

| | |
|---|---|
| information about care and treatment to make improvements. | |
| 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

- We saw improvements in learning disability reviews following improvements in the recall and review systems. Templates had been developed and integrated into the patient record system to ensure a consistent approach to the review process.
- The practice had identified that patients with chronic kidney disease (CKD) may not be coded accurately as the number of patients on their register was below the predicated prevalence. An initial search of patients with specific blood test results indicated 116 patients were not coded correctly but were being managed appropriately. The CKD register had been updated and further work was being considered to utilise the electronic system to assist coding in this area.

**Effective staffing**

## The practice was able to evidence staff had the skills, knowledge and experience to carry out their roles although some records were not up to date.

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

- The staff were provided with an annual training programme and access to two online training systems. External training was also provided during monthly meetings. For example, practical fire safety training had been provided at the last meeting as well as this being available online. Staff provided copies of their training plan and confirmed they had access to training systems and completed this training.

- The practice manager had a manual system to monitor training although this was not fully up to date. The manager could access staff records on the online system to check completion of staff training. The practice manager told us they would review the monitoring systems to ensure a consistent approach.

- *Induction processes were in place and new staff confirmed they had received induction training. Records were in place, but these had not been fully completed for the two most recent starters.

- *Staff supervision had been provided but two staff plus the practice managers supervision were overdue for 2018/19.

- Practice nurses told us they were supported in their training needs. Two of the practice nurses had attended training to provide the leg ulcer service. This had included shadowing community nurses.

- The practice manager told us training and induction records and supervision were not completely up to date for 2018/19 due to the extensive project management required in the recent building work.

**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. | NA |
| Explanation of any answers and additional evidence: | |

**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. | P* |
| 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 |
| Explanation of any answers and additional evidence: <ul><li>* The practice had identified they had not performed as well as they would like in in the provision of health checks and told us only 31% of eligible patients had received health checks. They told us this was due to previous lack of space and capacity. They had recently extended the building and increased the nursing team and were aiming to significantly improve performance in this area.</li></ul> | |

| 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) | 95.5% | 95.1% | 95.1% | No statistical variation |
| Exception rate (number of exceptions). | 0.2% (3) | 0.5% | 0.8% | N/A |

**Consent to care and treatment**

**The practice always obtained / was unable to demonstrate that it 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. | NA |
| Explanation of any answers and additional evidence: | |

# Well-led                                 Rating: Good

**Leadership capacity and capability**

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

| | Y/N/Partial |
|---|---|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Y |
| They had identified the actions necessary to address these challenges. | Y |
| Staff reported that leaders were visible and approachable. | Y |
| There was a leadership development programme, including a succession plan. | Y |
| Explanation of any answers and additional evidence: <ul><li>An extensive programme of expansion and renovation work to create more consulting space and improve the building had been undertaken in 2018/19. The level of project management this had involved had impacted on the practice managers time to keep some areas up to date such as training and supervision. They were aware of this and had been working to catch up since the work had been completed.</li><li>One of the GPs was completing training to become a GP trainer with a view to becoming a training practice for GP registrars.</li><li>The practice nurse team had been expanded and working hours changed to improve communication and flexibility of appointments.</li><li>A pharmacist had been employed to improve medicines management.</li></ul> | |

**Vision and strategy**

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

| | Y/N/Partial |
|---|---|
| The practice had a clear vision and set of values that prioritised quality and sustainability. | Y |
| There was a realistic strategy to achieve their priorities. | Y |
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Y |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Y |
| Progress against delivery of the strategy was monitored. | Y |
| Explanation of any answers and additional evidence:<br>• The schedule of meetings, including a daily 'huddle' for all staff, including management and partners, ensured good communication throughout the whole team. The staff told us they valued these meetings and felt involved in the development of the practice. | |

**Culture**

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

| | Y/N/Partial |
|---|---|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | Y |
| Staff reported that they felt able to raise concerns without fear of retribution. | Y |
| There was a strong emphasis on the safety and well-being of staff. | Y |
| There were systems to ensure compliance with the requirements of the duty of candour. | Y |
| When people were affected by things that went wrong they were given an apology and informed of any resulting action. | Y |
| The practice encouraged candour, openness and honesty. | Y |
| The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy. | Partial* |
| The practice had access to a Freedom to Speak Up Guardian. | Y |
| Staff had undertaken equality and diversity training. | Partial** |
| Explanation of any answers and additional evidence:<br>• *The practice had a whistle blowing policy although this did not reflect the NHS policy in relation to giving advice for staff on how to access a whistleblowing guardian (An independent and impartial source of advice to staff at any stage of raising a concern). | |

- **Equality and diversity training was part of the annual training plan given to staff and was available as part of an eLearning package which staff told us they accessed. The training log was not up to date and the manager was not able to accurately evidence which staff had completed which training when.

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

| Source | Feedback |
|--------|----------|
| Staff | All staff told us they were well supported and encouraged to undertake training which was made available electronically and via external events and training events in the practice. They told us the service had improved, particularly in respect of communication, and felt they were kept up to date with any changes. |

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

- The practice had an electronic document management system which enabled access to documents such as policies and procedures, incident and complaint records, guidance and meeting minutes. There was some slight inconsistency in the use of the system between some staff groups, so this was not used to its full potential.

**Managing risks, issues and performance**

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

| | Y/N/Partial |
|--|--|
| There were comprehensive assurance systems which were regularly reviewed and improved. | Y |
| There were processes to manage performance. | Y |
| There was a systematic programme of clinical and internal audit. | Y |
| There were effective arrangements for identifying, managing and mitigating risks. | Y |

| | Y |
|---|---|
| A major incident plan was in place. | Y |
| Staff were trained in preparation for major incidents. | Y |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Y |
| Explanation of any answers and additional evidence:<br>• A member of staff had the role of monitoring performance and providing data to the management team.<br>• Clinical audits were undertaken to monitor performance against good practice guidelines. | |

**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 |
| Staff whose responsibilities included making statutory notifications understood what this entails. | Y |
| Explanation of any answers and additional evidence:<br><br>• A member of staff had developed various data systems and patient record templates to promote consistency in the delivery of care to patients and support staff to monitor performance and improve care.<br>• Data, such as friends and family test information, was used to monitor patient experience. | |

**Engagement with patients, the public, staff and external partners**

## The practice involved 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 | Y |

| needs of the population. | |
|---|---|

| Explanation of any answers and additional evidence: |
|---|
| <ul><li>A regular schedule of meetings was held in the practice including a monthly multidisciplinary meeting, regular team meetings, daily staff huddles and meetings with the PPG. All meetings were recorded and stored on the practice electronic information system including notes from the daily huddles. Staff told us they found the system easy to access and valuable in keeping up to date with any changes.</li><li>The practice manager utilised social media platforms to communicate with patients and the practice website had been well developed to support patients access information.</li></ul> |

Feedback from Patient Participation Group (PPG).

| **Feedback** |
|---|
| <ul><li>Members of the PPG told us the practice worked well with them and they had regular meetings with the practice manager. They said meetings were held on different days and times to encourage attendance.</li><li>They told us they had been consulted about the changes to the building and felt involved in the development of the practice.</li><li>They said the provider listened to them and acted on their suggestions. For example, they had asked for the telephone message to be reviewed as it was too long, and the practice had changed the message.</li><li>They told us the work to the building had been well managed and the service had been maintained through very difficult circumstances.</li><li>They said they were involved with supporting the practice for example, assisting at the flu clinic by greeting patients, explaining the process and completing surveys.</li></ul> |

| **Any additional evidence** |
|---|
| <ul><li>We received 32 completed patient comment cards which were all extremely positive about the care and treatment provided. The service was described by many as excellent and staff as friendly, caring and helpful. They told us they were treated with respect and were listened to. Patients told us the appointment system worked well and they were complimentary about the system where they could email their preferred GP directly.</li></ul> |

**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 |

| Learning was shared effectively and used to make improvements. | Y |
|---|---|

**Explanation of any answers and additional evidence:**

- The staff were encouraged to complete training to improve their skills and provide additional services for patients. For example, the practice manager had completed a diploma in advanced practice management. The practice manager and the data manager had both completed an accountancy qualification. Two practice nurses had undertaken training to provide the leg ulcer clinic including compression bandaging and doppler testing. A GP and health care assistant had completed training in spirometry. One GP was undertaking training to become a GP trainer.
- Information was shared with staff through their meetings and the electronic document management system.

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## Examples of continuous learning and improvement

- The practice had improved access to appointments through the implementation of a new system which included e-consultation. This had significantly improved phone response time, wait for appointments and number of missed appointments. An improved web site complimented the new appointment system.
- The practice had developed the in-house leg ulcer service which provided good outcomes for patients. They had developed a template within the patient record system to support this service to ensure consistency of assessment.
- The service for learning disability patients had been reviewed and improved to ensure these patients received effective annual reviews.
- The practice nurse team had been expanded and included a practice nurse with a specialist interest in diabetes. They worked closely with the GP with specialist interest this area. Data showed above average performance compared to local and national figures for diabetes care and practice unverified data showed continuous improvement in this area. Staff told us the approach went beyond the treatment of patients with staff also encouraged to adopt healthy lifestyles.

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**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.