Care Quality Commission

Inspection Evidence Table

Roseheath Surgery Ltd (1-515104996)

Inspection date: 6 November 2019

Date of data download: 05 November 2019

Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

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
Explanation of any answers and additional evidence:	

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)	0.27	1.12	0.75	Variation (positive)

Prescribing	Practice performance	CCG average	England average	England comparison
(01/07/2018 to 30/06/2019) (NHSBSA)				

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.
- The practice carried out annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice followed up on older patients discharged from hospital. It ensured that their prescriptions were updated to reflect any extra or changed needs.

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

Findings

- Patients with a long-term condition were offered an annual review to check their health needs were being appropriately met.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Multi-disciplinary meetings were held with social and health service practitioners to review patients with complex and palliative care needs to ensure they had access to appropriate support.
- Patients were referred to services for support with their long-term health such as the low carbohydrate diet group. This group was run by the charity that had been developed by the provider and worked with a number of local voluntary organisations.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were referred for ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.

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 (01/04/2018 to 31/03/2019) (QOF)	72.4%	73.7%	79.3%	No statistical variation
Exception rate (number of exceptions).	5.6% (8)	9.0%	12.8%	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 (01/04/2018 to 31/03/2019) (QOF)	73.5%	78.5%	78.1%	No statistical variation
Exception rate (number of exceptions).	4.2% (6)	5.1%	9.4%	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 (01/04/2018 to 31/03/2019) (QOF)	80.6%	78.8%	81.3%	No statistical variation
Exception rate (number of exceptions).	5.6% (8)	7.5%	12.7%	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 (01/04/2018 to 31/03/2019) (QOF)	78.4%	73.0%	75.9%	No statistical variation
Exception rate (number of exceptions).	2.1% (3)	5.0%	7.4%	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 (01/04/2018 to 31/03/2019) (QOF)	90.9%	84.6%	89.6%	No statistical variation
Exception rate (number of exceptions).	6.1% (5)	5.5%	11.2%	N/A

Indicator	Practice	CCG	England	England

		average	average	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 (01/04/2018 to 31/03/2019) (QOF)	80.4%	84.4%	83.0%	No statistical variation
Exception rate (number of exceptions).	1.8% (6)	3.1%	4.0%	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 (01/04/2018 to 31/03/2019) (QOF)	95.5%	94.4%	91.1%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	5.9%	5.9%	N/A

Families, children and young people Population group rating: Good

Findings

- The practice had not met the minimum 90% target for the childhood immunisation uptake indicators.
- Uptake of childhood immunisations was monitored regularly. To improve uptake the provider gave all new parents information about vaccinations and baby clinics, texts and telephone call reminders were made, contact was made with parents who failed to bring a child to a vaccination appointment to remind them of the importance of this, alerts were placed on patient records, verbal reminders were made to patients and flexible appointments were offered.
- 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.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary. There were priority appointments before and after school.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- Patients were referred to sexual health services in the local area.

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	37	42	88.1%	Below 90% minimum

to 31/03/2019) (NHS England)				
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)	35	40	87.5%	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) (01/04/2018 to 31/03/2019) (NHS England)	35	40	87.5%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	34	40	85.0%	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: Requires Improvement

Findings

- The practice is rated requires improvement for this population group as cervical cancer screening uptake was below the 80% coverage target.
- Patients had access to appropriate health assessments and checks including NHS checks.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- The practice offered an extended hour service every Wednesday evening until 7.30pm.
- Telephone consultations and Econsult (email consultation service) were offered which assisted patients finding it difficult to attend an appointment.
- Patients were able to access an extended hours service provided by Knowsley CCG. Patients could also attend a walk-in centre.

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	68.9%	N/A	80% Target	Below 70% uptake

49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	60.8%	64.6%	72.1%	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)	42.7%	51.1%	57.3%	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)	55.6%	71.3%	69.3%	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)	50.0%	46.0%	51.9%	No statistical variation

Any additional evidence or comments

The improvement plan for the practice included work to increase patient access to cancer screening services and reviews of patients diagnosed with cancer. We saw action plans were in place to improve screening for bowel, breast and cervical cancers.

Cervical cancer screening was below the 80% coverage target. The provider was aware and was working to increase uptake by monitoring non-attendance, telephoning patients who had not attended, sending reminder letters on brightly coloured paper, sending reminder text messages, opportunistic screening and putting flags on the records of patients who had not attended so they could be reminded. The practice nurse had recently transferred to the service and was liaising with the provider regarding offering a late evening and Saturday cytology clinic.

The practice had collaborated with a local hospital to target women who had not attended for breast screening. A text message, email and direct mail campaign (which linked to a website article encouraging breast screening attendance) was sent to patients. The practice also collaborated with Breast Mates support group in Huyton to improve uptake. Information encouraging breast screening was on the practice website and included a video clip for patients to view. Posters were also displayed at the practice.

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.

- A carers register was held. Carers were identified and provided with relevant information about GP and local services. Information for carers was publicised and carers were offered an influenza vaccination.
- The practice referred or signposted bereaved relatives to support organisations where appropriate.
- The provider had developed a charity linked to the practice which worked with local voluntary organisations, to develop and provide services that could help prevent illness caused by debt, social isolation and other non-medical issues. The practices in the group could refer patients directly into these services. Stakeholders involved in providing a service to patients through the charity included a debt advice service, employment support and housing support. The charity also offered a walking group, exercise activities, creative classes, holistic therapies and coffee mornings with guest speakers.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Patients experiencing poor mental health, including dementia, were offered an annual review to check their health needs were being appropriately met.
- 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.
- 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 (01/04/2018 to 31/03/2019) (QOF)	84.8%	84.9%	89.4%	No statistical variation
Exception rate (number of exceptions).	5.7% (2)	10.7%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and	100.0%	87.9%	90.2%	Variation (positive)

other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	0.0% (0)	9.3%	10.1%	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 (01/04/2018 to 31/03/2019) (QOF)	75.0%	73.7%	83.6%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	7.3%	6.7%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	516.3	No Data	539.2
Overall QOF score (as a percentage of maximum)	92.4%	No Data	96.4%
Overall QOF exception reporting (all domains)	4.5%	No Data	No Data

	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
Explanation of any answers and additional evidence : There was a lead GP for clinical audits. They worked closely with the CCG to monitor the service provided and identify any areas of low performance. Administrative audits were also carried out to ensure that administrative processes were operating effectively.	

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

We reviewed clinical audit and assurance processes for osteoporosis and diabetes. The practice had commissioned an independent organisation to examine their clinical system and look for potential missed diagnoses to improve prevalence and disease registers and ways of optimising treatment and making prescribing cost savings. Following this an action plan had been developed which included a system for

reviewing patients.

In addition, audits in the last two years have included an audit of patients attending for breast screening. Due to the shortfalls identified action was taken to encourage uptake. The practice had also carried out an audit of atrial fibrillation to determine if patients were receiving the appropriate treatment. Action was taken to improve the treatment provided as a consequence. A plan was in place to carry out further audits in both areas.

A number of audits had been carried out regarding medication prescribing. A number related to patient safety alerts. We saw a spreadsheet which indicated that these audits were carried out annually after receiving the initial alert to ensure that safe prescribing practices were being adhered to. Examples of audits in the last two years have included an audit of antimicrobial prescribing, audits of medicines prescribed to female patients of child-bearing age and audits of high-risk medicines.

Any additional evidence or comments

The practice had started to use a pharmacist led information technology methodology for reducing medication errors and thereby improving medication safety.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction includes 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 incidents of aggression from patients was reported to be low. Some staff had received training in managing aggression and some had not. This was brought to the attention of the provider to be addressed.	

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 (01/04/2018 to 31/03/2019) (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	Y

services.	
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.	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
Explanation of any answers and additional evidence:	

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 (01/04/2018 to 31/03/2019) (QOF)	95.9%	95.6%	95.0%	No statistical variation
Exception rate (number of exceptions).	1.1% (6)	0.6%	0.8%	N/A

Consent to care and treatment

The practice 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
Explanation of any answers and additional evidence:	

Well-led Rating: Requires Improvement

A rating of requires improvement has been made because: -

- **The system for ensuring Patient Group Directives were appropriately authorised was not comprehensive.**

Leadership capacity and capability

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: The practice was part of a wider organisation managed by a senior management team with varied expertise and skills to promote a well-run service. The governance team included: A medical director who worked closely with local health, social care and education stakeholders. A business partner with responsibility to ensure finance was maximised for the benefit of patients who used the practice. A quality and safeguarding lead was responsible for ensuring the quality of the services provided met the needs of all stakeholders and improvements were planned for and made as required. A performance lead who monitored how the service was meeting patient outcomes. A lead for medicines management who ensured medicines were appropriately managed. A marketing and communication lead who engaged with patients, staff and other stakeholders to ensure all information was shared as required.	

Vision and strategy

The practice had a vision and 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: There was a business plan and a quality improvement strategy for the Maassarani Group of General Practices. These were developed with and shared with stakeholders and kept under regular review. The improvement plan for Roseheath Surgery Ltd included action to improve outcomes in diabetes, cancer screening and meeting the needs of patients with dementia.	

Culture

The practice had a culture which supported the provision of high quality 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.	Y
The practice had access to a Freedom to Speak Up Guardian.	N
Staff had undertaken equality and diversity training.	Y

Explanation of any answers and additional evidence:

We looked at the system to manage complaints and found that this was operating appropriately. We saw that an apology had been made following the investigation of a complaint.

Staff had access to a welfare telephone service which provided advice and guidance in a number of areas.

A whistleblowing policy was available for staff to refer to. This did not identify the Freedom to Speak Up Guardian and staff spoken with were not sure who this was.

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

Source	Feedback
Staff feedback	• Staff stated they felt supported. They had access to the training they needed for their roles and were encouraged to develop their skills. • Staff told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. • They told us there was good communication between all staff.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
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 service employed a professional marketing and communication lead who used different media to communicate and gain and use feedback from all stakeholders. There were various means of formal communication and informal communication at all levels between staff, senior managers and patients.

The governance lead chaired the practice management meetings across the Knowsley CCG. This provided the service with the opportunity to share and learn from good practice in practices across the area.

All policies and procedures were reviewed yearly. The practice had written standard operating procedures for all processes, these were reviewed to ensure they met best practice guidance and legal requirements. However, the system to ensure appropriate authorisation of patient group directives (PGDs) was not effective as we saw that they had not all been appropriately authorised. This was addressed on the day of the inspection.

Managing risks, issues and performance

Overall, there were clear and effective processes for managing risks, issues and performance, however an improvement was needed.

	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.	Partial
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:

Quality improvement and audit systems were comprehensive and assisted the practice to make changes to improve the service provided.

There were effective arrangements in place to identify, manage and mitigate risks. There were systems to ensure that staffing levels were sufficient to satisfy patient demand. The management team monitored demand for appointments and capacity to meet this. There were systems in place to receive and respond to patient safety alerts, significant events and complaints. There were systems to ensure that appropriate standards of cleanliness and hygiene were met and to ensure medicines were safely managed.

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. Staff had training in safeguarding vulnerable adults and children and there were processes in place to respond to requests for information from the local authority. There were systems to ensure the premises and equipment were fit for use. For example, there were risk assessments for health and safety and for the premises.

The system to ensure appropriate authorisation of patient group directives (PGDs) needed to be reviewed. A new nurse had commenced employment recently at the practice having transferred from one of the other practices from the Maassarani Group of General Practices. The PGDs had not been signed to indicate the competence of the nurse to provide two types of vaccinations. This was addressed at the inspection by the GP with responsibility in this area who also checked all PGDs to ensure they had been appropriately authorised.

Appropriate and accurate information

There was a 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:	

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 and additional evidence: The practice manager attended weekly management meetings with other practice managers from the services within the Maassarani Group of General Practices. An anonymised staff survey was carried out annually. There were themed away days for training and team building.	

Feedback from Patient Participation Group.

Feedback
The practice had a Patient Participation Group (PPG). We met with three members (two were very new) who told us that they met four times per year with a representative from the practice. They said they were kept informed about changes at the practice, asked their opinion and felt listened to. They said that changes had been made at the practice as a result of their feedback. For example, changes had been made to the appointment system and the layout of the reception area.

Any additional evidence
The practice sought patient feedback by utilising the NHS Friends and Family test (FFT). The FFT is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014. Results from August to October 2019 showed there had been 100 responses and 99 (99%) were either extremely likely or likely to recommend the practice. As part of this inspection CQC asked patients to complete comment cards indicating their views about the

service. Thirty-three comment cards were returned and 31 were positive about access, care and treatment. One response was mixed, and one was negative. The negative comments related to access and changes in clinical staff.

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:	

Examples of continuous learning and improvement
• The practice had taken part in pilots to improve the services offered to patients. For example, they had been part of the NHS pilot programme for pharmacists. Taken part in the physician associate training and in a CCG pilot to review how patients ordered medicines to address over-ordering of medicines. • The practice reviewed the service provided to patients and made changes to improve access. For example, the practice had introduced Econsult as a further way for patients to access clinicians. The practice was looking at digital solutions for the management of long-term health. • The practice was part of a primary care network (PCN) and was working within this to improve services for patients. • The practice was managed by a management leadership team which included professional finance, marketing and communication and quality assurance personnel. This team had developed an infrastructure which supported innovative ways of working; promoted sustainable improvements and high-quality care in all outcome areas. • One example of innovation was the development of a charity linked to the practice which worked with local voluntary organisations, to develop and provide services that could help prevent illness caused by debt, social isolation and other non-medical issues. The practices in the group could refer patients directly into these services.

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. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.

- 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.

- 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). This indicator does not have a CCG average and is scored against the national target of 80%.

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

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

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.