Care Quality Commission

Inspection Evidence Table

Hendford Lodge Medical Centre (1-545496303)

Inspection date: 30 October 2019

Date of data download: 29 October 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
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: Until April 2019 the practice had taken part in the Somerset Practices Quality Scheme (SPQS) rather than the Quality and Outcomes Framework (QOF). (QOF is a system intended to improve the quality of general practice and reward good practice). SPQS measured quality and outcomes differently with an emphasis on quality improvement activities. Under the SPQS framework reporting on QOF data was not used. This meant data below for 2018/19, which showed a negative variation, was not representative of the quality work undertaken at the time. Consequently, this practice showed more	

negative variation for long-term conditions and mental health when compared with other practices for 2018/19.

During our inspection we reviewed:

- The practice's SPQS quarter four 2018/19 action report which detailed actions taken in areas such as quality improvement and the implementation of treatment escalation plans.
- The SPQS 2018/19 Somerset Clinical Commissioning Group report which detailed work undertaken in the scheme's quality improvement areas of high blood pressure management, bone health and falls.
- We reviewed the unverified 2019/20 QOF data, from April through to October 2019, in particular those areas which indicated negative variations. We saw the practice's 'how am I driving' report and the end of year predictive report which indicated achievements were forecasted to be in line with national averages.

Since returning to QOF the practice was working with an external company to ensure patients' conditions were appropriately coded. Clinical review meetings to discuss QOF outcomes and coding of conditions took place regularly.

The practice had a range of services to meet patient's needs:

- A nurse led complex care team who worked with health coaches. They utilised a traffic light system to prioritise needs.
- An acute care team including a duty doctor and multi-disciplinary clinicians such as paramedics, and minor illness nurses.
- A Controlled drug management team (GP and Pharmacist) to monitor patients on high risk and controlled medicines.
- Pharmacists to monitor medicines and undertake patient reviews.
- A prescription ordering department (POD) was in place to monitor medicine requests and ensure patients on medicines that required regular reviews or screening tests had access to these.

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) (01/07/2018 to 30/06/2019) (NHSBSA)	0.35	0.66	0.75	Tending towards 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.
- The complex care nurse had recently been undertaking a project in residential and nursing homes to train staff in completing assessments that identified risk of serious illness such as sepsis.

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 complex care team worked with other health and care professionals to deliver a coordinated package of care. Clinical reviews included falls risk assessment, preventative care and social impacts on health.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice 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 prescription ordering department (POD) ensured patients attended annual and medicine reviews were necessary.

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)	65.0%	70.1%	79.3%	Variation (negative)
Exception rate (number of exceptions).	1.7% (15)	8.0%	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	61.2%	68.5%	78.1%	Variation (negative)

to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	3.8% (34)	6.8%	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)	80.9%	76.4%	81.3%	No statistical variation
Exception rate (number of exceptions).	5.5% (49)	11.1%	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)	61.8%	63.5%	75.9%	Variation (negative)
Exception rate (number of exceptions).	1.7% (18)	6.7%	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)	67.6%	74.1%	89.6%	Significant Variation (negative)
Exception rate (number of exceptions).	2.1% (8)	8.1%	11.2%	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 (01/04/2018 to 31/03/2019) (QOF)	79.7%	78.2%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.5% (64)	3.7%	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)	86.9%	88.3%	91.1%	No statistical variation
Exception rate (number of exceptions).	0.6% (2)	5.0%	5.9%	N/A

Any additional evidence or comments

The explanation for negative variations in data can be found on page one.

- The practice had invested in recruiting additional practice nurses with specialist respiratory and diabetes management training.
- They were supporting an additional nurse to undertake respiratory training.
- National support programmes such as 'My Diabetes My Way' were used to improve self-management of diabetes.
- All housebound patients with long term or complex conditions received an annual home visit review and where needed, were managed by the complex care team.
- An appropriate recall system for annual reviews was in place and regularly monitored.
- The practice had recruited an external company to undertake a QOF data check and disease register to identify high risk areas.
- A pharmacist led prescription administrative team (POD) actively recalled patients requiring monitoring for high risk medicines.

On the day of inspection we reviewed unverified QOF data:

- We saw, since the re-introduction of QOF targets the practice had a plan in place to ensure patients received appropriate reviews.
- We reviewed unverified data on the day of inspection and end of year projections and found the practice had improved areas where data previously indicated negative variations.
- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months had improved to 68%

Families, children and young people Population group rating: Good

Findings

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets.
- The practice 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.
- Saturday morning clinics were available and included appointments for six-week baby checks and cervical smears.
- An acute on the day service was accessible.

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)	119	123	96.7%	Met 95% WHO based target
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)	124	130	95.4%	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)	124	130	95.4%	Met 95% WHO based target
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)	124	130	95.4%	Met 95% WHO based target

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.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- The practice had appointments with a range of clinicians on a Saturday.
- Access to telephone consultations early morning and evening were available.

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)	66.9%	N/A	N/A	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	74.3%	73.9%	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)	57.8%	61.1%	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)	51.9%	45.1%	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)	54.5%	54.8%	51.9%	No statistical variation

Any additional evidence or comments

During our inspection the practice demonstrated they were working to improve cervical smear uptake rates:

- Patients could book a nurse appointment on a Saturday.
- The minor illness nurse was assisting with appointment availability for cervical smears.
- The practice had implemented a new process to ensure any clinics were only cancelled if other availability was available.
- Training for the nurse practitioners to undertake cervical cancer screening was being completed.

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

They worked with local drug and alcohol services.

- Home visits were available earlier in the day to assess those at risk of hospital admission.

Any additional evidence or comments

- The practice had identified 4% of the practice population as carers. They supported them with a carers' information board, access to a health coach where necessary and on the day appointments.

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. All calls for urgent support were assessed by a GP on the day.
- 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 developed and utilised a quick access computer function to enable access to support organisations.

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)	75.7%	51.5%	89.4%	Tending towards variation (negative)
Exception rate (number of exceptions).	4.6% (5)	9.8%	12.3%	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 (01/04/2018 to 31/03/2019) (QOF)	46.7%	55.4%	90.2%	Significant Variation (negative)
Exception rate (number of exceptions).	2.8% (3)	8.5%	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)	68.1%	61.6%	83.6%	Tending towards variation (negative)
Exception rate (number of exceptions).	4.8% (8)	6.4%	6.7%	N/A

Any additional evidence or comments

Quality Outcome Framework (QOF) data above relates to 2018/19 when the practice undertook the local Somerset quality scheme. (Further explanation is detailed on page one above). During our inspection we reviewed current of unverified QOF data from April to October 2019 for 2019/20 QOF:

- In 2019/20 the recording of alcohol consumption in this population group is no longer part of the QOF scheme.
- The percentage of patients diagnosed with dementia whose care plan had been reviewed in a face-to-face review in the preceding 12 months was 70%, which showed an improvement.
- The practice had a system to follow up patients diagnosed with dementia and ensure care plans were in place. As part of the local quality scheme (SPQS) the practice had been implementing treatment escalation plans and care plans for this population group.
- Patients phoning the practice, who experienced poor mental health, were provided with same day access to a GP.
- The practice had undertaken quality improvement work in relation to treatment escalation plans.
- The practice had developed a quick access process to enable clinicians to access the most up to date local organisations who support patients experiencing poor mental health.
- Staff were in the process of undertaking mental health first aid training.

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)	396.4	No Data	539.2
Overall QOF score (as a percentage of maximum)	70.9%	No Data	96.4%
Overall QOF exception reporting (all domains)	2.4%	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

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

An audit of Opiate and other high-risk medicines in chronic pain management:

- Identified patients were reviewed by the practice's controlled drug medicines team with recommendations made to named GPs.
- Dose reduction plans were agreed with patients and assessed at follow-up appointments.
- A 76% reduction in the numbers of patients who received high risk medicines for chronic pain management.
- A second cycle audit led to further reductions.

An audit to identify patients with a contraceptive intra-uterine device (Coil) found patients had correct documentation and were invited to see a GP for a review.

Any additional evidence or comments

The practice demonstrated an 'idea for audits' document was in place which was discussed at monthly clinical coordination meetings. An annual audit action plan or documentation of audits undertaken was not in place. Following inspection, the practice provided an audit register with second cycle audit dates.

Effective staffing

The practice was able to demonstrate 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 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.	Partial
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:

Receptionists had undertaken signposting training and administrative staff workplace optimisation training to improve document management.

The practice supported clinical staff to undertake further training to develop their skills:

- The extended care practitioner (ECP) was undertaking a prescribing course to enable them to prescribe medicines within their role;
- The complex care nurse was undertaking a variety of courses to develop the role further;
- A weekly acute care team meeting took place to review management of relevant clinical conditions.
- A weekly clinical meeting attended by all of the clinical team including trainee GPs ensured staff had the most up to date skills and knowledge.
- An annual training plan was in place in addition to the practices mandatory training. For example, face to face Mental Capacity Act update training.

The practice was slightly behind with staff appraisals due to a change in practice manager. However, we saw a plan was in place to ensure all staff had a completed appraisal by the end of 2019.

Following analysis of patients with long term conditions and complex needs two additional nurses were recruited to meet demand.

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

Explanation of any answers and additional evidence:

- A clinical coordination panel comprising of multi-disciplinary health and social care professionals met monthly for complex care patients. This included the practices health coaches who provide additional support to patients such as social prescribing in managing new or existing health conditions.
- The practice worked with end of life care organisations using the Gold Standard Framework (GSF). (GSF is a process that enables earlier recognition of the needs of patients with life-limiting conditions and helps patients and their carers to plan ahead). The practice utilised an IT system to ensure up to date information was accessible to healthcare professionals providing end of life care.
- Treatment escalation plans (STEP) were in place for those patients in the last few years of life. (STEP records clinical decisions which had been made with patient and carer involvement, as far as possible, on what treatments are appropriate. They are patient led and accessible to health and social care services supporting that patient).
- The complex care team (complex care nurse and health coaches) coordinated care between health, social care and voluntary organisations.

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: Additional services were available for patients to support a healthy lifestyle including social walks, flexercise classes and dietary advice from the health coaches.	

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)	87.2%	89.8%	95.0%	Significant Variation (negative)
Exception rate (number of exceptions).	0.7% (28)	1.1%	0.8%	N/A

Any additional evidence or comments
Following the practices return to QOF (Quality Outcomes Framework) from SPQS there were ongoing plans to ensure QOF data was up to date and information such as smoking status was being recorded accurately. (Further explanation can be found on page one above).

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
Explanation of any answers and additional evidence: • Staff undertook e-learning training on consent. We saw evidence a planned Mental Capacity Act update was in place.	

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:

In 2019 a merger of the partners two practices; Hendford Lodge Medical Centre and Abbey Manor Medical Practice took place. (The practice population was approximately 14,900, with 4,000 patients previously registered at Abbey Manor Medical Practice.) This meant patients had access to clinical staff including long term condition management and cervical smears across both sites.

Despite a shortage of GPs, the leadership team had successfully recruited a multi-disciplinary primary care team consisting of senior nurses including nurse practitioners, paramedics, minor illness nurses and pharmacists. The additional skill mixes allowed the practice to meet the challenges within primary care through development of an acute care team (on the day urgent requests and minor illness) and a complex care team which included the health coaches. Both teams were coordinated by a GP.

In addition, to improve resilience and sustainability within the practice they had introduced a pharmacist led prescribing admin team (POD) and had access to three GPs who provided remote administrative functions such as test result reviews for three sessions a week. Reception staff had received signpost training and administrative staff were trained in workforce optimisation including taking of additional documentation processes to improve GP availability.

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:

The practice had business objectives and a priority based action plan and work improvement plan.

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.	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: • The practice supported GP trainees (ST3) and trainee Doctors (F2). • The duty doctor for the acute team sat with the reception team to provide support and assist with patient signposting.	

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

Source	Feedback
Staff told us:	• The partners and the practice manager were open, approachable and listened to suggestions to improve the service. For example, a staff idea to prevent usage of the car park by the public was actioned. • The practice manager had an open door policy, was supportive and kept staff up to date on processes and changes. Staff gave examples of how the practice manager was always available to speak to patients when asked to. • All staff we spoke with, expressed their enjoyment of working within their roles and teams. They were all positive about the work the practice undertook to provide a service that met the needs of the practice population.

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: Since the commencement of employment of the new practice manager, a process to review governance within the practice was ongoing. This included: • Training for an administrator in HR processes. • A review of health and safety processes and risks. • Identification of a named GP who took responsibility for key areas such as quality improvement. • A review and update of existing policies, processes and systems with an action plan where potential risks had been identified.	

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
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: • The practice monitored and reviewed safety using information from a variety of sources. For example, there was a system for recording and acting on safety alerts. Staff understood how to deal with alerts. • Health and safety, premises, security, emergency medicines and infection prevention and control risk assessments were in the process of being updated in terms of actions that had been identified. Following inspection, the practice provided updated risk assessments and information to manage risks. For example, up to date DBS risk assessments had taken place for all	

non-clinical staff.

- Regular meetings took place such as a quarterly meeting for significant incidents and GP and practice nurse meetings.
- A clinical coordination panel met monthly to review new guidance; protocols; significant events; learning from incidents and complaints; quality outcome framework (QOF) monitoring and enhanced services.
- We saw positive actions and learning from incidents and complaints. For example, following a complaint of a misdiagnosis, we saw the practice supported the family through additional meetings and provision of counselling.
- Appointment availability versus demand was regularly reviewed. We saw as a result the practice had increased appointment availability including telephone appointments. This included an additional 15 face to face GP appointments for each morning and afternoon GP session.
- Workflow optimisation had allowed the reduction of locum GP usage.
- The clinical coordination panel reviewed clinical governance processes, new national guidance, significant event learning, QOF and any enhanced services provided.

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:

- The practice had a performance manager who reported to the clinical coordination panel.

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 had listened to staff in terms of patient difficulties parking in the car park due to the public using the spaces. A new system was introduced and the practice surveyed patients with regards to their experiences with this. 65% said they wanted to keep the new system which ensured parking and prevented non-patients utilising spaces.

The GP patient survey (2019) showed the practice was mostly in line with local and national averages with the exception of telephone and appointment access . The survey had a response rate of 48% which equated to 0.8% of the practice population. Results around timely access to the practice showed negative variations below national averages. During inspection we discussed these, and the practice demonstrated they had listened to patient concerns. This was confirmed by the patient participation group (PPG).

- A new telephone system had been introduced in October 2019 to deal with demand. The PPG undertook call audits to document accessibility and these were returned to the practice manager.
- The practice had recently reviewed the appointment system for GPs following introduction of systems and processes to reduce GP demand. They had substantially increased the amount of appointments available from November 2019, for on the day and routine appointments.
- A patient feedback survey on telephone and appointment access was due to be implemented.

The practice monitored patient feedback on review sites such as Google and NHS Choices as well as their Facebook pages.

Feedback from Patient Participation Group.

Feedback
The patient participation group (PPG) was part face to face meetings and part virtual meetings. They were an amalgamation of the PPG from both the practice's locations. We contacted members of the patient participation group who told us: • Patients who made a formal complaint were encouraged to become active members of the group. • The appointment booking system had been overhauled and had improved. Patients had noticed the improvements to the system. • The practice manager was very responsive to any concerns or complaints. She took the time to speak to patients personally. • Patients were always treated with dignity and respect. Staff were considerate and respectful.

- The practice shared its vision and future strategy for improvement.
- They had been kept updated in terms of the new phone system. They advised us the phone system had greatly improved.

CQC comments cards	
Total comments cards received.	14
Number of CQC comments received which were positive about the service.	11
Number of comments cards received which were mixed about the service.	3
Number of CQC comments received which were negative about the service.	0

Any additional evidence

Feedback from CQC comment cards:

- Staff are understanding, considerate and helpful.
- The practice manager is accessible and approachable.
- There is often a wait if patient's want an appointment with their own GP.
- Access to the practice and appointments have recently improved.

Continuous improvement and innovation

There was little evidence of 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

Examples of continuous learning and improvement

- The practice had developed the use of a computer key (F12) to enable fast and up to date access to information on local and national patient support groups and resources.
- A project to improve skills of residential and nursing home staff to recognise acute deterioration of a patient's condition had resulted in reduced contact with the practice; improved handover to practice staff (including NEWS2 sepsis scoring) and improved working with the local district hospital. As a result, the complex care nurse (as part of the collaborative project) had been nominated for an award for clinician and manager partnerships working with NHS Trusts.

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.