Care Quality Commission

Inspection Evidence Table

Litchdon Medical Centre (1-544066113)

Inspection date: 5 November 2019

Date of data download: 08 October 2019

Overall rating: Outstanding

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

Effective Rating: Good

In 2015 we found the practice had been outstanding in Effective for the following;

- The practice was involved in a national pilot to provide education about healthy living to patients identified at risk of developing diabetes.
- The practice provided outstanding dementia care, through GPs working closely with hospital specialists and mental health practitioners. All practice staff had dementia care training.
- Litchdon is a training practice where the quality of training provided was rated highly by GP registrars and medical students.
- Evidence based care was delivered to patients and followed national and local guidelines. Data showed that the practice had achieved high performance (100%) for monitoring patients with long term conditions and chronic health diseases. At risk groups were targeted for health screening, support and treatment.

At our most recent inspection in November 2019, we found an example of outstanding practice in the Effective domain;

- Proactively working on pilot schemes in North Devon to improve care at local care and nursing homes.

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:

GPs carried out validation and external appraisals. Quarterly clinical commissioning group (CCG) education sessions with different clinical topics. Most recently in October 2019 these included a microbiologist from the local hospital discussing urinary tract infections (UTIs) in the elderly, gynaecology, a dementia speaker and a Devon Carer's speaker.

The NICE guidance website was scrutinised regularly by the practice manager and information sent to lead GPs depending on their specialist areas.

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)	1.17	0.90	0.75	No statistical variation

Older people — Population group rating: Good

Findings
• Older patients had a named GP. Linked administrative staff were allocated to each patient and acted as a liaison point for community health and social care staff ensuring that support for patients was responsive and timely when needed.

- Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people and offered home visits and rapid access appointments for those with enhanced needs.

- 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 carried out structured 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. Flu clinics were held with other organisations and charities were invited. These included local support groups. The clinics provided a good opportunity to talk to patients in informal setting. Three flu clinics were held with approximately 900 patients attending each clinic. Other vaccines were also offered according to patient need, for example to reduce the risk of pneumonia.

- The practice had taken part in North Devon wide pilot for 16 weeks up to September 19, 2019 on proactive care and nursing home support in order to reduce admissions and emergency/crisis management. This was run by the practice and its primary care network. Due to its success at the practice (and across North Devon), it was due to restart in December 2019. During the pilot, practice GPs visited local care and nursing homes to review care, working alongside the nursing team in each care home. Issues were then identified, and care improved accordingly. The number of practice patients who benefitted during the initial pilot was seven. The next planned roll out following this successful pilot will benefit hundreds of patients at the practice.

People with long-term conditions Population group rating: Good

Findings

- All patients were linked with a named GP with the appropriate specialist skills and expertise in areas such as respiratory or cardiac medicine. Data showed that the practice performed highly for monitoring and treating patients with long term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. The same day team provided instant access to GP and nurse appointments which provided patients with proactive treatment and support reducing the risk of hospital admission.

- Longer appointments and home visits were available when needed. Patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

- 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. There were strong links with the North Devon integrated diabetes team and project. This included annual visits from the hospital diabetes team to do education sessions for GPs and nurses and to review complex patient cases.

- A podiatrist regularly attended the practice to check on patient's foot care, which was particularly relevant to diabetes.

- The practice held in house diabetic patient education sessions. Plastic food props were used to demonstrate appropriate portion sizes in healthy eating sessions.

- Identified the need to set up a child asthma education group session after school to try and encourage children to have their asthma reviews.

- Staff responsible for reviews of patients with long-term conditions had received specific training and were very experienced.

- The practice had enhanced the clinical monitoring of patients not normally covered under the Quality Outcomes Framework (QOF) by implementing Specific Disease Management (SDM) monitoring systems for ad hoc patients referred from secondary care back to primary care and require certain monitoring i.e. gastric banding, renal conditions, and anorexic patients. The practice SDM system ensured those patients not covered by the QOF received care according to their needs and went beyond contractual obligations.

- Clinical administration processes identified all discharge notes that said exacerbation of asthma or

COPD and they were tasked to the respiratory nurses to review the cases.

- The practice carried out monthly searches to identify patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. The practice regularly reviewed registers and ensured all eligible patients were on them. The practice employed an IT contractor to work from the practice every month in order to support the team with IT reporting systems such as QOF in order to ensure a high level of achievement in looking after patients.

- Patients with suspected hypertension were offered ambulatory blood pressure monitoring or home monitoring as appropriate. Patients with atrial fibrillation were assessed for stroke risk and treated appropriately. Patients with asthma were offered an asthma management plan.

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)	83.0%	82.9%	78.8%	No statistical variation
Exception rate (number of exceptions).	11.4% (99)	16.3%	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)	69.9%	76.7%	77.7%	No statistical variation
Exception rate (number of exceptions).	9.0% (78)	14.3%	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)	80.4%	81.6%	80.1%	No statistical variation
Exception rate (number of exceptions).	15.7% (137)	17.1%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	71.3%	76.0%	76.0%	No statistical variation
Exception rate (number of exceptions).	3.1% (33)	11.4%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	92.8%	89.9%	89.7%	No statistical variation
Exception rate (number of exceptions).	11.5% (36)	14.2%	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)	83.3%	83.7%	82.6%	No statistical variation
Exception rate (number of exceptions).	4.9% (104)	5.9%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	85.5%	90.1%	90.0%	No statistical variation
Exception rate (number of exceptions).	7.7% (24)	6.8%	6.7%	N/A

Families, children and young people Population group rating: Good

Findings

- The practice exceeded the minimum 90% minimum threshold for all four childhood immunisation uptake indicators.
- The practice exceeded the minimum 80% target for cervical cancer screening.
- The practice had a process for contacting the parents or guardians of children due to have childhood immunisations.
- Young people could access services for sexual health and contraception. Patients could book online appointments. This was a nurse led service which provided confidential access for young people.
- Staff had the appropriate skills and training to carry out reviews for this population group.
- The practice had links with the local health visitors and school nurses and had set up review meetings to discuss cases and families.
- The practice held child flu clinics in school holidays. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.
- All outpatient paediatric patients who did not attend (DNAs) were highlighted to the patients named GP.
- Nurse led contraception clinics were held regularly for women.
- There was a domestic abuse link worker in the practice. GPs and nurses referred patients straight to the link worker. Counselling, signposting and guidance supported these patients. This was part of the practice strategy which they linked with other agencies to tackle domestic violence.

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)	141	153	92.2%	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)	139	149	93.3%	Met 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)	138	149	92.6%	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)	138	149	92.6%	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 adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care to this population group. Lunchtime, extended evening appointments and weekend flu vaccination clinics were held to accommodate working age patients.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs of this group aged 40 to 74. For example, the practice had continued to run ‘well man’ and ‘well woman’ clinics despite the uptake of patients using this clinic was not at the level the practice was aiming for. The rationale for this was that further opportunistic screening could be offered to patients such as for chlamydia, cervical smears and mental health checks. 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 systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

- Patients could view their records on line and use the e-Consult service to get advice from their GP.
- The practice was part of the North Devon Improved Access scheme and offered early morning, evening and some weekend appointments as part of that scheme.
- The practice allowed 382 patients who lived outside their catchment area to remain as patients of the practice. This included patients who had moved away or wished to stay as patients, others are living elsewhere but work in Barnstaple.

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)	80.3%	N/A	80% Target	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	78.4%	75.4%	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)	63.0%	61.1%	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)	72.0%	63.9%	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)	48.7%	55.5%	51.9%	No statistical variation

Any additional evidence or comments

The practice ran specific clinics for cervical cancer screening in order to achieve the performance highlighted in the table above. The practice ran evening clinics, carried out opportunistic screening, raised awareness on social media platforms (Facebook and Twitter).

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. All patients had a named GP and linked administrative staff to promote patient centred care.

- The practice had carried out annual health checks for people with a learning disability (LD) and 100% of these patients had received a follow-up. It offered longer appointments for people with a learning disability. All patients with a learning disability were offered an annual health check. The practice had adapted the paperwork to be LD's friendly and pictorial to meet patient's communication needs.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- Same day appointments and longer appointments were offered when required.
- End of life care was delivered in a coordinated way, which took into account the needs of those whose circumstances may make them vulnerable. Fortnightly multi-disciplinary/ complex care meetings took place.
- The practice worked closely with other health agencies on shared care such as supporting patients with drug misuse and high-risk medicine prescribing.
- The practice had started a project in autumn 2019 as part of the Barnstaple Alliance PCN (primary care network) to develop healthcare services for homeless people. Working with the local council rough sleeping team, a homeless charity, and the CCG the aim being to provide an outreach clinic which at the moment would support 22 people.
- The practice were able to work with families who were from Syria as part of a national resettlement scheme. The practice worked closely with other agencies to achieve this.
- Social prescribing had been available in the practice for last two years. A Primary Care Network social prescriber worked at the practice 11 hours every week providing signposting, guidance and facilitation.

People experiencing poor mental health (including people with dementia)

Population group rating: Outstanding

Findings

- The practice held a register of patients experiencing poor mental health, including those diagnosed with dementia. Prompts within the patient record system highlighted when they had a career and any potential risks so that GPs focused on the support patients needed.
- Data showed that the practice engaged well with people experiencing poor mental health. For example, health screening performance for blood pressure, cholesterol, blood glucose and alcohol consumption ranged between 86.6 % and 97.8%.
- 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 was 98% which was higher than the CCG average of 89%. The practice had achieved this through regular audit and proactively encouraging these patients to attend their health reviews.
- The practice had completed cervical smears for 100% of female patients with complex mental health needs. The practice had completed care plans for 100% patients with complex mental health needs, which included identification of potential risks, actions to reduce these and carer

support.

- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia and demonstrated they were skilled and compassionate in supporting people.

- 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 and access the crisis team.

- A talking therapy service attended the practice once a week to provide cognitive behaviour therapy to patients.

- The practice provided an in-house free counselling service for staff and patients. Approximately 50 patients and two staff had used this service in the last 12 months. Each person saw the counsellor for between six to eight weeks. The practice provided the counsellor with a room at the practice.

- 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.

- A dementia support worker was contracted by the practice to work from the practice on a weekly basis. This member of staff provided support to patients with dementia and their carers and had attracted very positive patient feedback. They supported 35 patients a month.

- There was a dementia carers support group run at the practice. Dementia Friends training had been provided to all staff. This had led to the practice improving signage to make it easier to navigate.

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)	97.8%	89.0%	89.5%	Tending towards variation (positive)
Exception rate (number of exceptions).	7.2% (7)	16.6%	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)	95.5%	89.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	8.2% (8)	14.5%	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)	97.5%	84.0%	83.0%	Variation (positive)
Exception rate (number of exceptions).	4.8% (6)	8.1%	6.6%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	554.9	544.1	537.5
Overall QOF score (as a percentage of maximum)	99.3%	97.3%	96.2%
Overall QOF exception reporting (all domains)	5.2%	6.9%	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 information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years
• The practice had a range of complete cycle clinical audits which demonstrated monitoring and improvement. A regular clinical administration trend meeting took place which looked at these, together with near misses and significant events. • Clinical staff attended relevant seminars, most recently those concerning antibiotic stewardship education. • The healthcare administrative team had been trained in health navigation to increase the amount of time GPs could spend with patients. • The practice provided dedicated contraceptive coil fitting clinics and had carried out emergency exercises including training on actions to take in the event of patients experiencing anaphylaxis when fitting contraceptive coils.

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 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

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.	Y

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
The practice provided a great deal of information to help patients live healthier lives on their notice boards and on the website. Regular audits of patient groups helped the practice to achieve significant QOF results with health benefits to patients. The practice supported patients by having a proactive approach to booking patients in for their cervical cancer screening, bowel cancer and other essential health reviews.	

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)	95.1%	94.7%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.7% (28)	1.0%	0.8%	N/A

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y

Well-led Rating: Outstanding

We previously rated the practice as outstanding for providing a well-led service. In this inspection (November 2019) we found the practice had demonstrated sustained innovation and improvement since the last inspection.

In 2015 we found the practice to be outstanding in the following areas;

- The practice had a strong vision which had quality, safety and patient centred care as its top priority. A comprehensive business plan was in place, was monitored and regularly reviewed. This was discussed with all staff and shared with PPG members. High standards were promoted and owned by all practice staff.
- Innovative approaches were used to seek feedback from patients and involve them in health

promotion for the local population.

In 2019 we found the practice to be outstanding in the following areas;

- Providing leadership in the new primary care network in north Devon

- The practice drove innovation and improvement. For example, the practice had innovatively introduced the Specific Disease Management (SDM) review system. This captured information on patients with conditions not covered by the QOF, such as coeliac disease, bariatric surgery, eating disorders. Patient record markers alerted staff to the support these patients needed and instigated a system of regular reviews and follow ups.

- Overcoming significant challenges via strategic planning whilst achieving awards for sustainability and encouraging healthier lifestyles

- There was a focus on staff wellbeing. This included being a registered mindful employer, offering free mindfulness sessions, taster reflexology sessions, access to free counselling, table tennis and social events.

- The practice had a strong reporting culture and staff were willing to learn and improve. The practice encouraged significant events (SEAs) to be reported for openness and shared learning with other stakeholders took place.

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:

The practice provided leadership to the Primary Care Network (PCN) in the North Devon area. The practice five-year strategic plan initiated in 2014 had been achieved currently under review to be re-launched from 2020 – 2025. Areas like succession planning had been achieved, the recruitment and retention of staff, budgetary success and workforce planning. Other challenges which had been successfully met included a growing practice population and becoming a more sustainable, environmentally friendly practice, which successfully promoted healthier living to patients.

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:

- Team engagement had been undertaken across the practice to come up with the values and the mission statement. This included compassionate care, holistic well-being, positive teamwork, active listening and being family focused.
- The practice mission statement highlighted the importance of providing quality healthcare by valuing both patients and staff in a supportive and sustainable environment.
- Staff we spoke with throughout the practice knew the values and mission statement. These were on display at the practice.
- Regular meetings took place which included all practice staff (named “Mega meetings”) and encouraged staff participation in achieving joint targets to support patients at the practice in line with the values.

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:

Devon Local Medical Committee representatives had been appointed the freedom to speak up guardians and staff were aware of how to contact them.

All staff we spoke with told us they understood how to report any concerns should they wish to do so. Staff described an open culture with a strong focus on learning and development.

There was a focus on staff wellbeing. This included being a registered mindful employer, offering free mindfulness sessions, taster reflexology sessions, access to free counselling, table tennis and social events.

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

Source	Feedback
Staff	We spoke with a full range of staff at the practice including management, GPs, administration, reception and staff such as the dementia support worker who attended regularly. All staff we spoke with were extremely positive about their experience of working at the practice and the support they received from their line managers. Staff felt engaged with the practice values.

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: We looked at the following governance areas from the Safe domain and found that the practice had managed them effectively; Recruitment and training Information to deliver safe care Cleanliness and hygiene Appropriate and safe use of medicines Dispensary services Complaints and learning Safety alerts	

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

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Health and safety and Safety systems and records	
Premises/security risk assessment had been carried out. **Date of last assessment:** 21/08/19	Y
Health and safety risk assessments had been carried out and appropriate actions taken. **Date of last assessment:** 21/08/19	Y
There was a record of portable appliance testing or visual inspection by a competent person. **Date of last inspection/test:** Oct 2018	Y
There was a record of equipment calibration. **Date of last calibration:** 31/10/19	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. **Date of last check:** Nov 18	Y
There was a log of fire drills. **Date of last drill:** 14/05/19	Y
There was a record of fire alarm checks. **Date of last check:** 25/07/19	Y

Safeguarding	Y/N/Partial
There was a record of fire training for staff. **Date of last training:** 14/05/19	Y
There were fire marshals.	Y
A fire risk assessment had been completed. **Date of completion:** 25/07/19	Y
Actions from fire risk assessment were identified and completed.	Y

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

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Any unusual access was identified and followed up.	Y
Explanation of any answers and additional evidence: Online appointments, viewing medical records, electronic repeat prescriptions	

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

Feedback from Patient Participation Group.

Feedback
We spoke with the chair of the Patient Participation Group (PPG). The PPG currently had approximately 50 members. Meetings took place bi-monthly. The PPG was also carrying out joint meetings with the other three local practices. The most recent PPG meeting had taken place in July 2019. The PPG told us the practice listened to and acted upon their concerns from patients. These included feedback about faulty toilet hand dryers, a lack of bariatric chairs, a lack of large font writing on the visual display screen in the patient waiting area. The practice had acted upon and rectified all of these, to the satisfaction of the PPG. The PPG had provided extensive patient feedback to the practice about the need to become environmentally sustainable. The practice had listened to this feedback, acted upon it, and exceeded the expectations of the PPG through winning several awards for recycling, using sustainable energy and reducing waste, raising awareness of the health benefits of unpolluted air through reducing traffic. A further patient survey was planned for November 2019. The PPG had been provided with space on the practice website to reach patients. The PPG was engaged with the 'One Barnstaple' project which brought practices and voluntary sector agencies together, with other public services, to tackle local issues, such as homelessness and poverty. The PPG told us the practice responded to every comment on NHS Choices, reviewed their national GP Patient survey results were shared regularly with the PPG and actions agreed with the group. There was a quarterly patient newsletter and extensive use of social media to obtain patient feedback and increase awareness of health immunisation and screening campaigns.

Continuous improvement and innovation

There were 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

Explanation of any answers and additional evidence:

The practice had achieved the Devon Recycling Award for small businesses run by Devon County Council in 2019. The practice was the first practice in North Devon to participate in the national green impact awards aimed at health services. The practice had over three years achieved bronze, silver and gold accreditation. The practice had a green committee which included the PPG and a member from each department met quarterly to progress work on the environment. Future plans included implementing e-bikes for home visits. The mission statement included a focus on sustainability.

This was a training practice. Three GPs were accredited trainers. Of the 11 GP partners, half had previously been registrars with the practice demonstrating the practice was a desirable place to work. The practice was well known for its supportive environment of continuous learning and innovation. There were registrars, medical students, trainee nurses, paramedics and nurse associate students supported by the practice.

This was a research practice, engaged in level one research. Current research focussed on survivorship from cancer. The practice provided contraceptive coil fitting clinics and trained staff how to cope with related emergencies such as cervical coil shock.

The practice hosted regular learning events. Most recently on antibiotic stewardship education. Staff had been filmed by NHSE for a national webinar providing guidance on this topic.

There was a focus on staff wellbeing. This included being a registered mindful employer, offering free mindfulness sessions, taster reflexology sessions, access to free counselling, table tennis and social events.

Examples of continuous learning and improvement

- The practice drove innovation and improvement. For example, the practice had innovatively introduced the Specific Disease Management (SDM) review system. This captured information on patients with conditions not covered by the QOF, such as coeliac disease, bariatric surgery, eating disorders. Patient record markers alerted staff to the support these patients needed and instigated a system of regular reviews and follow ups.

- The practice had introduced new dictation software to reduce GP paperwork administration time and increase patient facing time.

- The practice had introduced Arden software and templates which provided prompts to avoid missing any essential information in treating patients.

- The practice was part of the South West Cancer Research UK pilot study for faecal Immunochemical Testing (FIT) which has now been rolled out nationally.

- The practice was working with the One Barnstaple community project which provided a joined-up approach with other agencies to tackling local issues such as the significant homeless population.

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