Care Quality Commission

Inspection Evidence Table

Goldington Avenue Surgery (1-545749862)

Inspection date: 02 December 2019

Date of data download: 29 November 2019

Overall rating: Good

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

Safe Rating: Good

Safety systems and processes

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

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

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence: The practice held a full record of immunisation history for clinical staff. For non-clinical staff, the practice had completed a risk assessment as not all staff members were able to provide a full immunisation history. They had assessed the risk as low as it was likely staff had received their childhood vaccinations. Staff were able to access occupational health at the local hospital.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: November 2019	Y
There was a record of equipment calibration. Date of last calibration: July 2019	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: November 2019	Y
There was a log of fire drills. Date of last drill: June 2019	Y
There was a record of fire alarm checks. Date of last check: November 2019	Y
There was a record of fire training for staff. Date of last training: Ongoing	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: March 2019	Y
Actions from fire risk assessment were identified and completed.	Y

Explanation of any answers and additional evidence:

We saw evidence that PAT testing had been booked to ensure it was completed on an annual basis.

The practice conducted safety checks of fire equipment such as extinguishers and emergency lighting on a weekly basis. An external company was invited into the practice on a six-monthly basis to service fire equipment.

We saw evidence that actions identified in fire risk assessments, such as ensuring that staff had clear roles and responsibilities in the case of fire, had been completed. We saw that staff had received information regarding what to do in the event of a major incident affecting the premises.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: November 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: November 2019	Y

Explanation of any answers and additional evidence:

The practice had completed a health and safety risk assessment and highlighted that hazards in walkways needed to be checked to prevent slips and trips. The practice had also highlighted that the patient stairlift should be used under staff supervision and therefore the activation key is held at reception.

The security risk assessment completed by the practice detailed CCTV, panic buttons and opening and closing procedures.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met however, the infection prevention and control policy required strengthening.

	Y/N/Partial
There was an infection risk assessment and policy.	Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: May 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

The practice had an infection control policy in place however, it lacked details of the cleaning of non-single items, such as blood pressure cuffs or thermometers. It also lacked details of notifiable diseases and management of outbreaks. However, staff were able to describe how to contact Public Heath England if necessary. Shortly following the inspection, the practice submitted evidence of a revised policy that included notifiable diseases and outbreaks. They had also developed a cleaning policy and schedule for non-single use items.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence: The nursing team had spent time with the reception team to ensure they were able to identify the 'red flag' symptoms of sepsis or other acute illness such as stroke. They had also developed a list of symptoms that were available, for reference, in reception.	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
Explanation of any answers and additional evidence: The practice had identified two significant events regarding referral management and this had been discussed with the relevant GP and trainee GP's. The practice had commenced a log of urgent referrals to ensure patients were followed up appropriately.	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation however, there was some gaps in the monitoring of fridge temperatures.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.84	0.87	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) (NHSBSA)	7.6%	8.6%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)	6.04	5.90	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	2.59	2.14	2.08	No statistical variation

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

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

Explanation of any answers and additional evidence:

The practice had one non-medical prescriber however, this clinician did not prescribe for acutely ill patients. A policy was in place for informal supervision and there was time booked within clinics for a debriefing with the lead clinician.

The practice ensured that repeat prescriptions were checked by a GP or a pharmacist. Certain medicines, such as emergency medicines for respiratory diseases, had a controlled number of repeat prescriptions that could be authorised prior to a clinician review.

The practice had identified slight rises in the use of broad-spectrum antibiotics. They had completed a two-cycle audit where the initial results were discussed at a clinical meeting. The second cycle showed a reduction in inappropriate prescribing of antibiotics.

Emergency medicines were held in an accessible area and checked monthly by the nursing staff. The defibrillator and oxygen were also regularly checked. We saw that there was emergency equipment for both adults and children.

We saw that systems were in place to check fridge temperatures to support the cold-chain however, we saw there were gaps in some of the readings. However, the practice also used a computerised system that logged the temperature, and this was reviewed on a weekly basis. We saw that the fridge temperatures had remained within the recommended range.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong however, minutes of discussions needed strengthening.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	13
Number of events that required action:	13
Explanation of any answers and additional evidence: We reviewed meeting minutes and saw that significant events were discussed at clinical meetings however, meetings were brief and required strengthening. Significant events were not a standing agenda item. The lead nurse attended the clinical meetings and cascaded information to the rest of the nursing team. Significant events were also reviewed for trends every six months by the management team.	

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

Event	Specific action taken
There were two occasions where urgent referrals were not sent.	Specific clinicians reflected on the incidents. The practice had commenced a log of urgent referrals, so these could be followed up by medical secretaries.
A child received an incorrect immunisation	The nursing team informed Public Health England and the patient's family. The practice had implemented a two-nurse child immunisation clinic to ensure that all vaccinations were checked twice. Nurses we spoke to told us that vaccines were checked prior to inviting the patient into the room to prevent distraction.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: Patient safety alerts were stored on the practice computer system and shared with staff. They were discussed at clinical meetings. We saw examples of actions taken on recent alerts for example, regarding sodium valproate and hormone replacement therapy.	

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

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) (01/10/2018 to 30/09/2019) (NHSBSA)	1.07	0.81	0.74	No statistical variation

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 practice was pro-active in encouraging patients to take up vaccination by contacting them regularly. The practice had also conducted community events where vaccination was offered.

People with long-term conditions Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Patients with long-term conditions were offered longer appointments where necessary and could have multiple conditions reviewed at one appointment.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Practice nurses followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- 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. The practice had utilised a quick screening method for atrial fibrillation and any diagnosis was confirmed with a full electrocardiogram. This method meant that patients were diagnosed earlier and treatment could be commenced.
- Patients with COPD were offered rescue packs where appropriate.
- Patients with asthma were offered a written 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 (01/04/2018 to 31/03/2019) (QOF)	80.3%	80.4%	79.3%	No statistical variation
Exception rate (number of exceptions).	15.1% (75)	16.2%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) (QOF)	74.4%	75.9%	78.1%	No statistical variation
Exception rate (number of exceptions).	13.5% (67)	12.7%	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)	83.6%	83.5%	81.3%	No statistical variation
Exception rate (number of exceptions).	15.3% (76)	14.2%	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)	75.4%	77.2%	75.9%	No statistical variation
Exception rate (number of exceptions).	22.0% (133)	9.3%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	90.0%	90.7%	89.6%	No statistical variation
Exception rate (number of exceptions).	16.7% (24)	14.7%	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)	84.2%	81.8%	83.0%	No statistical variation
Exception rate (number of exceptions).	9.4% (124)	4.9%	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)	89.9%	94.3%	91.1%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	4.0%	5.9%	N/A

Families, children and young people Population group rating: Good

Findings

- The practice had met the minimum 90% target for three of the four childhood immunisation uptake indicators. The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for one of the four childhood immunisation uptake indicators.
- 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.
- The practice hosted a regular midwife clinic for pregnant women.
- 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, including immunisation training.

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)	126	130	96.9%	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)	125	138	90.6%	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)	125	138	90.6%	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)	124	138	89.9%	Below 90% minimum

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

Any additional evidence or comments

The practice was proactive in increasing the availability of appointments for child immunisations in order to increase uptake. We saw that clinics were scheduled at various times of the day to fit in with patients' lifestyles. We also saw that a second nurse had been added to the clinics in response to a significant event. The practice told us this has also increased the efficiency of this clinic and had improved access.

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.

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)	74.5%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	69.5%	73.2%	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)	61.2%	56.3%	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)	40.4%	60.9%	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)	54.2%	55.8%	51.9%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- The practice had led on changes within the locality to improve identification of patients with a learning disability between primary and secondary care (hospitals). This scheme has been taken up by local hospitals and other practices to ensure appropriate information is shared.
- 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 met with community teams and discussed all patients on the palliative register. The practice had implemented the End of Life Quality Improvement programme since the previous inspection. This had been taken up by the local commissioning group and implemented across the locality. This programme assisted with identification of patients that may be approaching the end of life, facilitated discussions with the multi-disciplinary team and prompted advance care planning.
- 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. Appropriate referrals were made to local support resources.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

- The practice had high numbers of patients who had been exception reported and therefore did not have care plans in place. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.) The practice had a recall system that ensured all patients were contacted on at least three occasions before they were excepted.
- The practice had become a dementia friendly practice through using dementia champions and an action plan of improvements. The practice developed this extensive action plan using best practice identified in various national projects. We saw that the practice had implemented actions such as changing the colour of toilet seats and reducing the number of information posters in waiting areas. The practice had discussed this project with the Primary Care Network and it had been rolled out to other local practices.
- 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. We saw self-care information in waiting areas.
- 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.
- There was a system in place to ensure that uncollected prescriptions for patients with poor mental health were checked regularly and flagged to the GP for follow up.
- 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. The practice used electronic tools to assess for memory loss. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.

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)	90.3%	91.2%	89.4%	No statistical variation
Exception rate (number of exceptions).	41.5% (44)	17.8%	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)	92.9%	90.1%	90.2%	No statistical variation
Exception rate (number of exceptions).	47.2% (50)	15.4%	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)	72.1%	84.2%	83.6%	No statistical variation
Exception rate (number of exceptions).	4.2% (3)	9.2%	6.7%	N/A

Any additional evidence or comments
The practice was aware of the high exception rates in these areas. We saw evidence of a recall system where patients were invited to attend the practice multiple times prior to being exception reported, however this had not decreased exception rates. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

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)	551.7	No Data	539.2
Overall QOF score (as a percentage of maximum)	98.7%	No Data	96.4%
Overall QOF exception reporting (all domains)	7.4%	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

The practice completed many clinical audits and utilised the skills of GP registrars to ensure these were in line with the most up-to-date guidance (A GP registrar is a fully qualified and registered doctor who is completing further training to become a GP).

Regular searches were undertaken of patients who had been prescribed anticoagulants but were not managed by the practice. These patients were reviewed and any problems with their management was identified and resolved.

The practice completed monthly audits of patients over the age of 75 years who had suffered from a fractured hip. Treatment was reviewed to ensure that bone sparing treatment had been prescribed by secondary care.

The practice had completed a two-cycle audit regarding minor surgery. The first cycle was completed in March 2019 where improvements were needed within monitoring and documentation of the procedure followed. This was discussed at clinical meetings and the results had improved in the September 2019 audit.

Two cycle audits had also been completed regarding the management of antibiotics and this had resulted in a decrease in prescribing of inappropriate antibiotic prescribing.

Effective staffing

The practice was able 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.	Partial
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

The practice had an induction checklist for new staff however, we saw that a practice nurse who had been employed by the practice for two weeks had not yet completed safeguarding training. However, this staff member had a good understanding of the signs of abuse and how to escalate concerns. Shortly following the inspection, we received evidence that this had been completed.

The practice had oversight of training and mandatory training for all other staff members had been completed. Staff told us they felt supported in their learning and development and had the opportunity to discuss this at annual appraisals.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A

Explanation of any answers and additional evidence:

We saw that regular palliative care meetings were held to discuss patients with palliative and end of life care needs. The practice was proactive in identifying patients who were nearing the end of their life and providing appropriate support and signposting.

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: The practice used posters in the waiting room to advise patients of national campaigns, such as flu vaccinations. Self-care leaflets were also available.	

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)	91.6%	94.7%	95.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	1.0% (22)	0.8%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence: The practice had a mental capacity act policy in place that outlined capacity assessments and best interest decisions. The clinical staff we spoke with understood Gillick competencies and Fraser Guidelines. Gillick competence is concerned with determining a child's capacity to consent. Fraser guidelines are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.	

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: Staff told us that they were comfortable raising concerns to management teams. They felt confident that these would be addressed.	

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 developed a practice vision that prioritised patient care and providing gold-standard care. The staff we spoke with were able to explain their role in achieving this. At the time of the inspection, we saw that a staff meeting had been planned to further develop this vision.	

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 had a system to deal with complaints and a policy in place that ensured patients were informed of things that went wrong, for example, when an incorrect child immunisation was given. Staff were able to explain the duty of candour.

There was a whistleblowing and grievance policy in place that was accessible to all staff. Staff told us they would be happy to raise concerns and felt listened to.

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

Source	Feedback
Staff interviews	Staff told us they felt proud to work at the practice and they were supported by management teams. They told us there was a culture of teamwork and friendliness.
Patient interviews	Patients told us that staff members were always polite and friendly. Patients also reported that reception staff were helpful and appeared to be enjoying their roles. We were also told that clinicians took time to listen to patients and explain their treatment plans. We were given several examples of staff going above and beyond to ensure that patients received good quality care.

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: Staff we spoke with told us they were fully confident within their roles and felt that management teams were supportive. We saw evidence that there were regular meetings with external contractors such as cleaners and extended hours services.	

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 had a business continuity plan in place. They had also developed a 'power cut' box that included items that would be needed in case of a major incident. This included a recovery laptop, printed information and torches. Staff we spoke with were aware of the location of this box and what was held inside it.	

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
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: The practice manager monitored both clinical indicators and organisational processes. Organisational and clinical audits were completed and shared with staff. We saw evidence that learning was shared, and improvements were made.	

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 however, they did not have an active patient participation group.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	N
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 did not have an active patient participation group however, they had a group of patients who received more in-depth details of the running of the practice. The practice told us these patients did not want to meet formally.	

Feedback from Patient Participation Group.

Feedback
We met with two members of the practice mailing list. These patients told us they received regular updates from the practice. They told us they were comfortable to raise concerns or suggestions with the practice and felt these would be acted upon. All patients we spoke with were positive about the level of access and care within the practice.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

Examples of continuous learning and improvement
The practice had led on several areas of innovative practice. Following practice pilots, these schemes had been implemented by the other practices in the locality. The practice had led on changes to improve identification of patients with a learning disability between primary and secondary care (hospitals). This scheme has been taken up by local hospitals and other practices to ensure appropriate information is shared. The practice had become a dementia friendly practice. The practice drew upon best practice from projects, around the country and developed its own extensive action plan. . This included reducing signage, changing the colour of toilet seats and creating champion roles. This had been adopted by the Primary Care Network and local practices were also completing actions to achieve the accreditation. The practice also held learning events to support other practices in achieving this. Since the previous inspection, the practice had completed an End of Life Improvement programme where they had increased the level of communication between the multi-disciplinary team, increasing the number of patients identified as entering the last phase of their life and the care planning available to them. The practice had identified technology to provide atrial fibrillation screening that involves a heart tracing using a fingertip device. Atrial fibrillation (AF) is a risk factor of stroke and early identification and diagnosis can improve patient outcomes. The practice piloted this, and it was then implemented by six other practices in the locality through the Primary Care Network. The clinical commissioning groups have plans to take this forward and implement the use of the device in 48 further GP practices. . It has been in place since April 2018 and the practice have diagnosed 14 patients with AF and there has been 48 diagnoses across the locality.

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.