Care Quality Commission

Inspection Evidence Table

Martock Surgery (1-6022485147)

Inspection date: 3 March 2020

Date of data download: 25 February 2020

Overall rating: Good

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

Effective Rating: Good

We inspected the practice in April 2019 and rated the practice as good for all population groups, apart from patients with long term conditions and patients experiencing poor mental health (including dementia), which we rated as requires improvement.

We rated Effective as requires improvement and we identified an area where the practice must make improvements and issued a requirement notice for a breach of Regulation 12 Safe care and treatment:

- **The provider must ensure that the monitoring of patients registered with long term conditions, mental health needs and dementia received regular reviews of their care.**

We told the provider they should:

- **Continue to deploy resources to address the administrative backlog of work.**
- **Ensure that management vacancies at the practice are filled in a timely manner to minimise disruption to the service.**
- **Continue to focus on increasing the number of cervical smear checks and other cancer screening, in line with national guidance.**

Following this inspection we rated effective and the population groups as 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

Until April 2019 the practice had taken part in the Somerset Practices Quality Scheme (SPQS) rather than the Quality and Outcomes Framework (QOF). (QOF is a system intended to improve the quality of general practice and reward good practice). SPQS measured quality and outcomes differently with an emphasis on quality improvement for a reduced number of indicators. Under the SPQS framework reporting on some indicators, such as the QOF data below which showed a negative variation were not included, meaning the negative variation in achievement shown were not always representative. The 2018/19 data in this evidence table reflects data prior to the practice merger with Symphony Health Services (SHS) in December 2018. However, the practice had undertaken audits to ensure areas identified as poor achievement, were fully reviewed and where necessary additional action taken to improve patient outcomes. During inspection, we reviewed information including action plans. We spoke to SHS clinical leadership team and practice staff to understand areas that currently showed lower than national average data. Although some areas required further work to meet targets, we were assured there was no current patient risk. Data trajectories showed a significant increase in long-term condition reviews since November 2019.

During inspection we reviewed the current QOF (unverified) data and spoke to the clinical lead, practice nurses and Symphony Health Services clinical board. Since our previous inspection (April 2019) the practice had reviewed disease registers and identified areas of action. For example, reviewing clinical codes for disease diagnosis within patient records.

We found:

- The practice undertook a daily huddle meeting and a clinical tea break to allow for clinical discussions of care and treatment.
- The disease registers were reviewed monthly.
- The clinical staffing structure had been reviewed and vacancies recruited to. This included the addition of an advanced nurse practitioner as clinical lead.

- To improve annual review uptake, the practice had assigned daily annual review appointments to clinicians and changed the recall system.
- Whilst undertaking recruitment to the practice nurse team, specialised locum nurses had been recruited, on a regular basis, to review patients with a chronic condition.
- A multidisciplinary team had been developed to improve the effectiveness of care delivered by directing patients to the most appropriate person for their need. The team included advanced nurse practitioners, emergency care practitioners, a clinical pharmacist, a musculoskeletal practitioner and health coaches. (Health coaches are trained staff who provide non-clinical support and advice).
- We saw clinicians were supported by clear clinical pathways and protocols. For example, they used a bespoke template and clinical pathway system (Q Master) which ensured improvement in the quality of the data within patient records. The system ensured appropriate coding of treatment provided in line with QOF.
- The provider had reviewed the prescribing of hypnotic medicines (sedatives) and were undertaking work with the clinical commissioning group (CCG) to monitor prescribing.
- The provider, Symphony Health Services, provided monthly monitoring in the form of a scorecard and feedback. The scorecard had key performance indicators, for example, patient DNA (did not attend) rates; QOF monitoring. In addition, weekly updates on QOF progress were provided to the practice.
- Daily huddles and bi-weekly huddles with the secondary care complex care team took place where concerns such as safeguarding or changes in a patient's condition were discussed.

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)	0.85	0.64	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.
- 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. Treatment escalation plans (TEP) were implemented and followed up by the health coaches. (A TEP is a plan of care made with the patient and/or carer to manage clinical deterioration).
- Twice weekly visits to local nursing homes were undertaken.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

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.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Clinicians followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.
- Health coaches provided patients at risk of developing diabetes (pre-diabetics) one to one coaching. (Health coaches are trained staff who provide non-clinical support and advice).

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)	63.6%	70.1%	79.3%	Variation (negative)
Exception rate (number of exceptions).	2.6% (18)	8.0%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) (QOF)	59.3%	68.5%	78.1%	Variation (negative)
Exception rate (number of exceptions).	4.8% (34)	6.8%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) (QOF)	70.7%	76.4%	81.3%	Variation (negative)
Exception rate (number of exceptions).	10.5% (74)	11.1%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) (QOF)	28.2%	63.5%	75.9%	Significant Variation (negative)
Exception rate (number of exceptions).	1.7% (12)	6.7%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	34.7%	74.1%	89.6%	Significant Variation (negative)
Exception rate (number of exceptions).	3.1% (7)	8.1%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)	77.0%	78.2%	83.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	3.2% (64)	3.7%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)	85.8%	88.3%	91.1%	No statistical variation
Exception rate (number of exceptions).	4.2% (15)	5.0%	5.9%	N/A

Any additional evidence or comments

Previously (April 2019) we told the practice to improve the monitoring of patients registered with long term conditions. This was because there had been a historic backlog in the provision of annual reviews.

During inspection we reviewed the most recent data from April 2019 until the date of inspection, (the practice joined the Quality and Outcomes Framework (QOF) scheme in April 2019). Prior to this, the practice was a part of a local quality scheme and a new provider commenced the service in December 2018. The data below is currently unverified however it showed an improvement from the practice QOF data for 2018/19 (above). Where the practice remained under the target for each indicator the practice had an action plan in place which we reviewed, and which was subject to a monthly review by the provider. This included utilising permanent locum nurses to complete reviews for long-term conditions before the end of year. We spoke to the locum nurses one of which was a specialist diabetic nurse who had plans in place to work towards expected targets, this included conducting over the phone annual consultations. End of year forecasts indicated the practice would meet the targets although this was currently unverified. For example:

- The percentage of patients with diabetes, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months was 55% (target 35% - 75%).
- . The percentage of patients with diabetes, with moderate or severe frailty in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months was 91% (target 52-92%)The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading is 140/80 mmHg or less had improved to 67% (target 78%).
- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months was 68% (target 45% to 70%). To reach maximum target 13 patients required a review.
- The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness was 78% (target 50% to 90%) with 13 further patients requiring review for the practice to meet maximum target.
- 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 was 92% which was within target range.

Indicators for hypertension (high blood pressure) had changed within the 2019/20 QOF year. We saw these were in line with QOF minimum and maximum targets. For example:

- The percentage of patients with a history of stroke, with a last blood pressure reading of 140/90mmHg, under 80 years was 61% (maximum target 77%) and over 80 years with a history of stroke and a reading of 150/90mmHg was 80% (maximum target 86%).

Since our previous visit the practice had:

- reviewed care and treatment provided prior to the merger and found no concerns.
- the practice were reviewed coding of medical diagnosis and worked towards improving these. For example, diabetic patients had received appropriate care however this had previously been recorded incorrectly.
- worked with the hospital respiratory team to ensure information was relayed to the practice following a hospital patient review. For example, letters detailing the review contained information such as results for assessments of breathlessness.
- recruited a health care assistant with spirometry training (an assessment of breathlessness). This meant the waiting list for patient's requiring this procedure had been completed.
- implemented a pre-diabetic patient group run by health coaches. Health coaches also provided flexercise classes and had been trained to undertake frailty assessments. They were currently

reviewing all frailty scores for diabetic patients to ensure patients were coded correctly and assigned the correct quality indicator for blood glucose level expectations against frailty scoring
- recruited a practice nurse with advanced training in asthma
- locum nurses with respiratory and diabetes specialists had been providing regular assistance to improve the availability of patient reviews.
- ensured chronic disease patients had received a medicines review whilst they had waited for an annual review of their condition. The practice were also offering telephone reviews of long-term conditions where clinical observations and tests had been recently completed.
- implemented a text reminder service for annual review appointments and other information such as smoking status.
- provided patients with high blood pressure, home monitoring machines.

Families, children and young people Population group rating: Good

Findings

- The practice had met the minimum 90% for 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 three of four childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisation.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

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)	76	80	95.0%	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)	81	86	94.2%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for	82	86	95.3%	Met 95% WHO based target

Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)				
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)	82	86	95.3%	Met 95% WHO based target

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

Working age people (including those recently retired and students) — Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- Improved access through out of normal surgery hours and Saturday surgeries were available.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 01/07/2019 to 30/09/2019) (Public Health England)	75.8%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	79.2%	71.7%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	64.0%	61.4%	58.0%	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. (01/04/2018 to 31/03/2019) (PHE)	9.8%	45.6%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	49.6%	56.6%	53.8%	No statistical variation

Any additional evidence or comments
On our previous inspection in April 2019 we told the practice they should continue to focus on increasing the number of cervical smear checks and other cancer screening, in line with national guidance. The practice had implemented changes as a result: • The practice had trained an additional practice nurse in cervical screening. • Health coaches telephoned patients who had previously declined a cervical smear. They had encouraged these women to attend for screening. • The practice was providing an additional clinic on Saturday's and outside of normal practice hours for women to book for cervical screening. • Coding on patient records had been reviewed and women who had undergone a hysterectomy had been removed from the recall system. • A text system was used to remind patients to book an appointment in additional to telephone calls and letters. • Future patient cervical smear awareness evenings had been planned. • Reviewed coding for cancer reviews post diagnosis and improved recording of these. During our inspection we looked at the data for the practice for QOF for 2019/20 (unverified): • 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 was 79%. • Cervical screening data for patients aged from 25 to 49 years of age and 50 to 64 years of age who had undertaken screening within expected timeframes were both 78%.

People whose circumstances make them vulnerable

Population group rating: Good

Findings
• Same day appointments and longer appointments were offered when required. • All patients with a learning disability were offered an annual health check. • End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. • The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. • The practice demonstrated that they had a system to identify people who misused substances. • The practice reviewed young patients at local residential homes.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings
• The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. • Same day and longer appointments were offered when required. • There was a system for following up patients who failed to attend for administration of long-term medication. • When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. • Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. • All staff had received dementia training in the last 12 months. • Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	42.2%	51.5%	89.4%	Significant Variation (negative)
Exception rate (number of exceptions).	4.5% (3)	9.8%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	44.6%	55.4%	90.2%	Significant Variation (negative)
Exception rate (number of exceptions).	3.0% (2)	8.5%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	47.6%	61.6%	83.6%	Significant Variation (negative)
Exception rate (number of exceptions).	4.1% (7)	6.4%	6.7%	N/A

Any additional evidence or comments
Previously (April 2019) we told the practice to improve the monitoring of patients experiencing poor mental health (including dementia) because the practice was not able to demonstrate an effective system was in place to monitor these patients. This was because, under the SPQS scheme mental health quality work was undertaken differently.

Since our previous inspection the practice:

- Provide dedicated twice weekly ward rounds in nursing homes.
- Had a complex care GP with a specialist interest in mental health who carried out dementia reviews.
- Have worked with local nursing and residential homes to support them with up to date care plans.
- Have allocated daily appointments for GPs for mental health patient reviews.
- Worked with a community NHS Trust to host a mental health practitioner weekly (from March 2020).
- Recruited a specialist nurse for dementia.

We reviewed QOF data from April 2019 to present day:

- 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 had improved from 42% to 64% (unverified data).
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded had improved from 44% to 78% (unverified data).
- The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review had improved from 47% to 60% (unverified data).

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)	333.6	441.3	539.2
Overall QOF score (as a percentage of maximum)	59.7%	78.9%	96.7%
Overall QOF exception reporting (all domains)	2.7%	4.2%	5.9%

	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

Any additional evidence or comments
The practice had a quality improvement and audit log. Since April 2019 the practice had undertaken a number of quality improvement activities including QOF related audits for end of life care and safe prescribing and high risk medicines monitoring.

An end of life care audit had reviewed patients aged over 75 living in supported care. The audit resulted in these patients having an appropriate treatment escalation plan and an advanced care plan in place. These were reviewed quarterly or sooner if required.

The practice was involved in provider and primary care network (PCN) quality improvement work.

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

At the time of our previous inspection (April 2019) the practice manager and deputy practice manager had recently vacated their roles. The provider was providing management support and a recruitment process had been instigated. There were a number of other vacancies which had impacted the practice. For example, at the time we found an administrative backlog. The new provider was in the process of introducing their new induction programme for staff joining the practice.

At this inspection we reviewed vacancy rates which showed improvements. There was a GP vacancy for 15 sessions per week however the practice had regular, GP locum cover in place. One locum GP supported workflow and there were no administrative backlogs. An action plan to review and manage ongoing recruitment including succession planning was in place.

The provider had reviewed staffing structures and implemented a multi-disciplinary clinical team. The practice had benefited from the merger of prescription management, into their medicine's management hub.

Since our previous visit the provider had implemented a competency based induction programme for staffing areas. For example, nurse practitioner inductions were linked with national nursing competencies.

Staff had received major incident training which had been put into practice during an incident whereby the local village lost electrical power.

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.	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

- Health coaches run a pre-diabetes group and flexercise classes.
- The practice employed health coaches to encourage patients to adopt healthier lifestyles through activity such as walking and exercise groups, healthy eating and reducing social isolation.
- Since our previous inspection information on support groups was widely available within the practice, through health coaches and on the practice website.

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)	84.2%	89.8%	95.0%	Significant Variation (negative)
Exception rate (number of exceptions).	0.7% (22)	1.1%	0.8%	N/A

Any additional evidence or comments
During inspection we reviewed the above data. Unverified data from April 2019 until the inspection day showed an achievement of 90% (target 90%).

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

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.