**LINCOLNSHIRE LOCAL MEDICAL COMMITTEE (LMC)**


# Care Quality Commission (CQC) Inspection Preparation Document

**AUTHOR**

Lincolnshire Local Medical Committee (LMC) Limited

**INSPECTION DATE:**

TBC

**DATE OF DATA DOWNLOAD:**

TBC

**Please note**: Any Quality Outcomes Framework (QOF) data relates to 2016/17 unless otherwise stated.

INTENTIONALLY BLANK

# Table of Contents



 

# Safe

## Safety systems and processes

### Safeguarding

| SAFEGUARDING | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| There was a lead member(s) of staff for safeguarding processes and procedures. | • Name the lead and the deputy | • All staff aware who they are | | | | |
| Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff. | • Safeguarding Children Policy<br>• Vulnerable adult policy<br>• Clinical Meeting Minutes<br>• Safeguarding Minutes<br>• FGM policy<br>• Safeguarding Noticeboard<br>• Safeguarding topic pages | •<br>•<br>•<br>•<br>•<br>•<br>• | | | 33<br>25<br><br><br>80 | |
| Policies were in place covering adult and child safeguarding | • Safeguarding Children Policy<br>• Vulnerable adult policy | •<br>• | | | 33<br>25 | |
| Policies were updated and reviewed and accessible to all staff. | • Safeguarding Children Policy<br>• Vulnerable adult policy | •<br>• | | | 33<br>25 | |

| SAFEGUARDING | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs) | • Training Matrix | • | | | 70 | |
| Information about patients at risk was shared with other agencies in a timely way. | • Safeguarding Children Policy<br>• Vulnerable adult policy<br>• Safeguarding Minutes<br>• Safeguarding Referral Forms | •<br>•<br>•<br>• | | | 33<br>25 | |
| Systems were in place to highlight vulnerable patients on record.<br><br>There was a risk register of specific patients | • How are vulnerable patient identified in your clinical system<br>• Safeguarding – identifying the vulnerable and safeguarding patients of all ages policy<br>• Searches in Clinical System | •<br>•<br>• | | | | |
| Disclosure and Barring Service checks were undertaken where required | • DBS Policy<br>• Evidence of DBS undertaken<br>• Risk assessments if no DBS has been done<br>• Annual declarations | •<br>•<br>•<br>• | | | 2 | |

| SAFEGUARDING |
| --- |
| Explanation of any ‘No’ answers: |

## Recruiting Systems

| RECRUITING SYSTEMS | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | • New employee recruitment, selection, Interview and appointment policy<br>• Locum Policy<br>• Staff Files<br>• Locum Information | • <br>• <br>• <br>• | | | 58<br>50 | |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role. | • Records of staff vaccinations | • | | | 37 | |
| Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | • Record of NMC and GMC checks and ongoing review | • | | | 26 / 56 / 66 | |
| Staff who require medical indemnity insurance had it in place | • Indemnity evidence and ongoing reviews<br>• Indemnity for locums | • <br>• | | | 50 | |

| RECRUITING SYSTEMS |
| --- |
| Explanation of any answers:<br><br>DBS checks in TeamNet<br>• See training matrix<br>• Only staff that have undergo chaperone training will chaperone<br>• Chaperone Policy<br><br>Chaperones were trained?<br><br>Training matrix (MYTH 70)<br><br>Chaperones had DBS?<br>• DBS checks (MYTH 2)<br><br>Chaperone policy in place?<br>• Chaperone Policy( to include the only staff who have been DBS can chaperone) (MYTH 15)<br><br>Poster to advise patients of the chaperone policy |

## Safety Records

| SAFETY RECORDS | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| There was a record of portable appliance testing or visual inspection by a competent person.<br>Date of last inspection/Test: | • Evidence of PAT testing | • | | | 52 | |
| There was a record of equipment calibration.<br>Date of last calibration: | • Evidence of Calibration testing | • | | | | |
| Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals | • COSHH folder<br>• Data Sheets + risk assessment for each product<br>• Secure Storage<br>• Signage | •<br>•<br>•<br>• | | | 86 | |
| Fire procedure in place | • Fire Safety Policy<br>• Appropriate signage | •<br>• | | | HSE | |
| Fire extinguisher checks | • Internal Checks<br>• External Checks | •<br>• | | | | |
| Fire drills and logs | • Fire drill log<br>• Review of fire drills<br>• Assembly point | •<br>•<br>• | | | | |
| Fire alarm checks | • Internal Checks | • | | | | |

| SAFETY RECORDS | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| | • External Checks | • | | | | |
| Fire training for staff | • Training Matrix | • | | | 70 | |
| Fire marshals | • Training Matrix | • | | | 70 | |
| Fire risk assessment<br>Date of completion | • Fire Risk assessment completed by a competent person | • | | | | |
| Actions were identified and completed | • Make sure all actions are reviewed and completed | • | | | | |
| Additional observations | | | | | | |
| Health and safety Premises/security risk assessment?<br>Date of last assessment: | • Risk assessment carried out by a competent person | • | | | HSE | |
| Health and safety risk assessment and actions<br>Date of last assessment: | • Risk assessment carried out by a competent person | • | | | HSE | |
| Additional comments: | | | | | | |

## Infection Control

| INFECTION CONTROL | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| Risk assessment and policy in place | • Risk assessment<br>• Cleaning audits<br>• Handwashing audits<br>• Clinical waste Audits | •<br>•<br>•<br>• | | | 5 / 6 / 7 / 27 / 54 / 76 | |
| Date of last infection control audit | • Within the last 12 months | • | | | | |
| The practice acted on any issues identified | • Make sure all actions are reviewed and completed | • | | | | |
| Additional observations | | | | | | |
| The arrangements for managing waste and clinical specimens kept people safe? | • Consignment notes<br>• Clinical waste protocol<br>• Waste Audit<br>• Pre acceptance Health Audit<br>• Infection control Audit<br>• Spillage Protocol<br>• IC meeting minutes | •<br>•<br>•<br>•<br>•<br>•<br>• | | | | |

| INFECTION CONTROL | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| | • PPE policy | • | | | | |
| | • Specimen Handling Policy<br>• Disposable instrument policy<br>• Yellow Bins are locked at all times and either in a bin shed or secured to the property | •<br>•<br>• | | | | |
| Explanation of any answers: | | | | | | |
| Any additional evidence: | | | | | | |

## Risks to Patients

| RISKS TO PATIENTS | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| There was an effective approach to managing staff absences and busy periods | • Examples of rotas<br>• Examples of how you cover holidays, sickness | •<br>• | | | LMC | |
| Comprehensive risk assessments were carried out for patients | • Risk assessments carried out by a competent person | • | | | | |
| Risk management plans were developed in line with national guidance | • Risk assessments carried out by a competent person | • | | | | |
| Staff knew how to respond to emergency situations | • Panic alarm protocol<br>• Fire Procedures<br>• CPR training<br>• Emergency drugs<br>• Resus training<br>• Sepsis training | •<br>•<br>•<br>•<br>•<br>• | | | 9 | |
| 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. | • Posters/aids for reception staff to use<br>• Training (sepsis) | •<br>• | | | 88 | |
| In addition, there was a process in the practice for urgent clinician review of such patients | • Visiting Policy<br>• Policy reflecting urgent clinical reviews | •<br>• | | | | |

| RISKS TO PATIENTS | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| The practice had equipment available to enable assessment of patients with presumed sepsis. | • BP<br>• Temperature<br>• Pulse Oximeter (adult and Child) | • <br>• <br>• | | | 1 / 88 | |
| There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance. | • Tools embedded in you clinical systems<br>• Easy access to sepsis guidance | • <br>• | | | | |
| Explanation of any answers: | | | | | | |

## Information to Deliver Safe Care and Treatment

| INFORMATION TO DELIVER SAFE CARE AND TREATMENT | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation. | • CQC may review clinical records on the day of the visit<br>• Record keeping audit | •<br>• | | | 65 | |
| Referral letters contained specific information to allow appropriate and timely referrals. | • Use of referral facilitation services<br>• Referral templates<br>• Peer review | •<br>•<br>• | | | | |
| Referrals to specialist services were documented. | • Use of referral facilitation services<br>• Referral templates | •<br>• | | | | |
| The practice had a documented approach to the management of test results and this was managed in a timely manner. | • Test result policy (any clinician should be aware).<br>• CQC may look at the amount of outstanding results still to be filed (process for communicating and managing an abnormal result). | •<br>• | | | 4 | |

| INFORMATION TO DELIVER SAFE CARE AND TREATMENT | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| 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 | • Clinical system sharing<br>• Out of hours sharing | •<br>• | | | 22 / 38 | |
| Explanation of any answers: | | | | | | |

## Appropriate and Safe Use of Medicines

| APPROPRIATE AND SAFE USE OF MEDICINES | | | | |
|---|---|---|---|---|
| **INDICATOR** | **PRACTICE** | **CCG AVERAGE** | **ENGLAND AVERAGE** | **ENGLAND COMPARISON** |
| ( to ) NHS Business Service Authority - NHSBSA) | | | | |
| 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). (01/07/2017 to | | | 8.7% | |

## Medicines Management

| MEDICINES MANAGEMENT | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | • How medications are carried out and by whom<br>• Prescribing Audit<br>• Recording of medication issues by another organisation (reconciliation after discharge/clinic visit). | •<br>•<br>• | | | | |
| Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions). | • Signed PSDs and PGDs<br>• Old PSDs / PGDs kept as per you retention policy (advised 8 years or until the child is 25) | •<br>• | | | 19 | |

| MEDICINES MANAGEMENT | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| Prescriptions (pads and computer prescription paper) were kept securely and monitored. | • Prescription Security Policy<br>• Prescription logs | •<br>• | | | 23 | |
| There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. | • Shared Care drug policy<br>• Prescribing Protocol<br>• Audit of high risk drug monitoring | •<br>•<br>• | | | 84 | |
| The practice monitored the prescribing of controlled drugs. (For example audits for unusual prescribing, quantities, dose, formulations and strength). | • Audits<br>• Prescribing Protocol<br>• Annual controlled drug self-assessment and annual declaration | •<br>•<br>• | | | 28 | |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | • | • | | | | |

| MEDICINES MANAGEMENT | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| If the practice had controlled drugs on the premises there were systems for the safe ordering, checks on receipt, storage, administration, balance checks and disposal of these medicines in line with national guidance. | • Annual controlled drug self-assessment and annual declaration. | • | | | 28 | |
| Up to date local prescribing guidelines were in use. | • Use of Optimise RX<br>• PACEF bulletins<br>• Prescribing meetings | •<br>•<br>• | | | | |
| Clinical staff were able to access a local microbiologist for advice. | • Access to local microbiologist on telephone (make sure staff are aware of this) | • | | | | |
| For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance. | • Remote access policy | • | | | | |
| The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held. | • Risk Assessments<br>• Drug expiry checks<br>• Anaphylaxis box and IUS fitting | •<br>•<br>• | | | 9 | |

| MEDICINES MANAGEMENT | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases. | • Oxygen annual service<br>• In house checks carried out to check levels | •<br>• | | | | |
| There was medical oxygen on site. | • | • | | | | |
| The practice had a defibrillator. | • | • | | | | |
| Both were checked regularly and this was recorded | • Defib checks<br>• Oxygen checks | •<br>• | | | 1 / 23 | |
| Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use. | • Cold chain audit<br>• Fridge temp monitoring<br>• Cold chain policy<br>• Fridge services | •<br>•<br>•<br>• | | | 17 | |
| Explanation of any answers: | | | | | | |

| DISPENSING PRACTICES ONLY | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| There was a GP responsible for providing effective leadership for the dispensary. | • Name of GP responsible for leading the dispensary | • | | | | |
| Access to the dispensary was restricted to authorised staff only. | • SOP stating who should have access to the dispensary<br>• Sign on dispensary door – "Authorised staff only" | •<br>• | | | | |
| The practice had clear Standard Operating Procedures for their dispensary staff to follow. | • All SOPs used in the dispensary | • | | | | |
| The practice had a clear system of monitoring compliance with Standard Operating Procedures. | • Demonstrate how the practice monitor compliance to the SOPs | • | | | 11 | |
| Prescriptions were signed before medicines were dispensed and handed out to patents. There was a risk assessment or surgery policy for exceptions such as acute prescriptions. | • Risk assessment or SOP | • | | | | |
| If the dispensary provided medicines in weekly or monthly blister packs (Monitored Dosage Systems) there were systems to ensure appropriate and correct information on medicines were supplied with the pack. | • SOP for Monitored dosage systems | • | | | | |

| DISPENSING PRACTICES ONLY | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| Staff were aware of medicines that were not suitable for inclusion in such packs and had access to appropriate resources to identify these medicines. Where such medicines had been identified staff provided alternative options that kept patients safe. | • | • | | | | |
| The home delivery service, or remote collection points, had been risk assessed (including for safety, security, confidentiality and traceability). | • Risk assessment for remote collection points | • | | | | |
| Information was provided to patients in accessible formats e.g. large print labels, braille labels, information in variety of languages etc. | • Accessible information policy | • | | | | |
| There was the facility for dispensers to speak confidentially to patients and protocols described process for referral to clinicians. | • Confidential area | • | | | | |

| DISPENSING PRACTICES ONLY | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| Explanation of any answers: | | | | | | |
| Any other comments on dispensary services: | | | | | | |

## Track Record on Safety and Lessons Learned and Improvements

### Significant Events

| SIGNIFICANT EVENTS | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| There was a system for recording and acting on significant events | • Significant event policy and form | • | | | 3 | |
| Staff understood how to report incidents both internally and externally | • Significant event policy and form<br>• Blame free culture policy<br>• Being open policy<br>• Duty of Candour<br>• Datix<br>• Whisteblowing | • <br>• <br>• <br>• <br>• <br>• | | | 3 / 24 | |

| SIGNIFICANT EVENTS | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| There was evidence of learning and dissemination of information | • Places you may have to report to<br>  • Controlled drug officer<br>  • NHSE<br>  • CCQ<br>  • CQC<br>  • FGM<br>  • IG toolkit<br>  • ICO<br>  • Infectious diseases<br>  • MHRA<br>  • NPSA<br>  • RIDDOR<br>  • Safeguarding<br>  • NHS fraud<br>  • Imms and Vaccs team | • | | | | |
| | • Trend analysis meetings and review of outcomes.<br>• Understanding of near misses and their importance.<br>• Whole team involved / ethos positive. | • | | | | |
| Number of events recorded in last 12 months | • | • | | | | |
| Number of events that required action | • | • | | | | |

| EXAMPLE(S) OF SIGNIFICANT EVENTS RECORDED AND ACTIONS BY THE PRACTICE | |
|---|---|
| **EVENT** | **SPECIFIC ACTION TAKEN** |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## Safety Alerts

| SAFETY ALERTS | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| There was a system for recording and acting on safety alerts | • Safety Alert protocol | • | | | | |
| | • Who receives, how disseminated, action recorded and inclusion in meetings. | • | | | | |
| | • List of alerts with actions | • | | | | |
| Staff understand how to deal with alerts | • Safety Alert protocol<br>• Minutes of meetings | •<br>• | | | | |
| Comments on systems in place (Evidence of ongoing reviews of alerts e.g. batch reporting) | | | | | | |
| Any additional evidence | | | | | | |

# Effective

## Effective Needs Assessment, Care and Treatment

### Prescribing

| PRESCRIBING | | | | |
|---|---|---|---|---|
| **INDICATOR** | **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) (01/07/2017 to 30/06/2018) (NHSBSA) | | | | |

### People with long-term conditions

| DIABETES INDICATORS | | | | |
|---|---|---|---|---|
| **INDICATOR** | **PRACTICE PERFORMANCE** | **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 (01/04/2016 to 31/03/2017) (QOF) | | | 79.5% | |
| **QOF EXCEPTIONS** | **PRACTICE EXCEPTION RATE (NUMBER OF EXCEPTIONS)** | **CCG EXCEPTION RATE** | **ENGLAND EXCEPTION RATE** | |
| | | | 12.4% | |

| DIABETES INDICATORS | | | | |
|---|---|---|---|---|
| **INDICATOR** | **PRACTICE PERFORMANCE** | **CCG AVERAGE** | **ENGLAND AVERAGE** | **ENGLAND COMPARISON** |
| 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 (01/04/2016 to 31/03/2017) (QOF) | | | 78.1% | |
| **QOF EXCEPTIONS** | **PRACTICE EXCEPTION RATE (NUMBER OF EXCEPTIONS)** | **CCG EXCEPTION RATE** | **ENGLAND EXCEPTION RATE** | |
| | | | 9.3% | |
| **INDICATOR** | **PRACTICE PERFORMANCE** | **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 (01/04/2016 to 31/03/2017) (QOF) | | | | |
| **QOF EXCEPTIONS** | **PRACTICE EXCEPTION RATE (NUMBER OF EXCEPTIONS)** | **CCG EXCEPTION RATE** | **ENGLAND EXCEPTION RATE** | |
| | | | 13.3% | |

| OTHER LONG TERM CONDITIONS | | | | |
|---|---|---|---|---|
| **INDICATOR** | **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 (01/04/2016 to 31/03/2017) (QOF) | | | 76.4% | |
| **QOF EXCEPTIONS** | **PRACTICE EXCEPTION RATE (NUMBER OF EXCEPTIONS)** | **CCG EXCEPTION RATE** | **ENGLAND EXCEPTION RATE** | |
| | | | **7.7%** | |
| **INDICATOR** | **PRACTICE** | **CCG AVERAGE** | **ENGLAND AVERAGE** | **ENGLAND COMPARISON** |
| 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 (01/04/2016 to 31/03/2017) (QOF) | | | 90.4% | |
| **QOF EXCEPTIONS** | **PRACTICE EXCEPTION RATE (NUMBER OF EXCEPTIONS)** | **CCG EXCEPTION RATE** | **ENGLAND EXCEPTION RATE** | |
| | | | 11.4% | |
| Any additional evidence or comments | | | | |

## Families, Children and Young People

| CHILD IMMUNISATION | | | | |
|---|---|---|---|---|
| **INDICATOR** | **NUMERATOR** | **DENOMINATOR** | **PRACTICE %** | **COMPARISON TO WHO TARGET** |
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2016 to 31/03/2017)(NHS England) | | | | Met 90% minimum (no variation) |
| 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) (01/04/2016 to 31/03/2017) (NHS England) | | | | Met 90% minimum (no variation) |
| Any additional evidence or comments | | | | |

## Working age People (Including those Recently Retired and Students)

| CANCER INDICATORS | | | | |
|---|---|---|---|---|
| **INDICATOR** | **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) (01/04/2016 to 31/03/2017) (Public Health England) | | | 72.1% | |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE) | | | | |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE) | | | | |
| 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. (PHE) | | | | |

| CANCER INDICATORS | | | | |
|---|---|---|---|---|
| **INDICATOR** | **PRACTICE** | **CCG AVERAGE** | **ENGLAND AVERAGE** | **ENGLAND COMPARISON** |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE) | | | 51.6% | |

Any additional evidence or comments

- Ask for updated data.
- What do they do to encourage cervical screening attendance?
- Breast and bowel screening?
- NHS health checks – number offered and number completed.
- Meningitis vaccine offered eligible patients?

Vulnerable People:

- End of life care coordinated
- What meetings are in place
- Register of patients
- System to vaccinate patient with underlying medical condition according to recommended schedule
- Learning disability health checks – number of people with a learning disability and number who have received a health check and timescale

## People Experiencing Poor Mental Health (Including People with Dementia)

| MENTAL HEALTH INDICATORS | | | | |
|---|---|---|---|---|
| **INDICATOR** | **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 (01/04/2016 to 31/03/2017) (QOF) | | | 90.3% | |
| **QOF EXCEPTIONS** | **Practice Exception rate (number of exceptions)** | **CCG Exception rate** | **England Exception rate** | |
| | | | 12.5% | |
| **INDICATOR** | **PRACTICE** | **CCG AVERAGE** | **ENGLAND AVERAGE** | **ENGLAND COMPARISON** |
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF) | | - | 90.7% | |
| **QOF EXCEPTIONS** | **Practice Exception rate (number of exceptions)** | **CCG Exception rate** | **England Exception rate** | |
| | | | **10.3 % / 6.8 %** | |

| MENTAL HEALTH INDICATORS | | | | |
|---|---|---|---|---|
| **INDICATOR** | **PRACTICE** | **CCG AVERAGE** | **ENGLAND AVERAGE** | **ENGLAND COMPARISON** |
| Any additional evidence or comments | | | | |

## Monitoring Care and Treatment

| INDICATOR | PRACTICE | CCG AVERAGE | ENGLAND AVERAGE |
|---|---|---|---|
| Overall QOF score (out of maximum 559) 2016-2017 | | | 539 |
| Overall QOF exception reporting (all domains) | | | 9.9% |
| Overall QOF score (unverified data) 2017-2018 | | | |
| Overall QOF exception reporting (all domains) 2017-2018 | | | |

## Coordinating Care and Treatment

| CQC REQUIREMENT | SUGGESTED EVIDENCE | PRACTICE EVIDENCE | LOCATION | OWNER | CQC MYTH BUSTER | COMPLETION STATUS |
|---|---|---|---|---|---|---|
| The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2016 to 31/03/2017) (QOF) | • Clinical audits<br>• Number of single cycle audits:<br>• Number of other audits with repeat cycles:<br>• Example of audit with positive outcome improvement for patients:<br>• Any national improvement initiatives involved in?<br>• Social prescribing scheme<br>• Work with carers register<br>• National improvement priorities | •<br>•<br>•<br>•<br>•<br>•<br>•<br>• | | | | |

## Helping Patients to Live Healthier Lives

| 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 (01/04/2016 to 31/03/2017) (QOF) | | | 95.2% | |
| QOF EXCEPTIONS | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | | | 0.8% | |

## Consent to Care and Treatment

| DESCRIPTION OF HOW THE PRACTICE MONITORS THAT CONSENT IS SOUGHT APPROPRIATELY |
| --- |
| Childhood immunisation: |
| Minor Surgery: |
| Contraception: |
| Mental Capacity: |
| Any additional evidence:<br>• Training – safeguarding adults and children, infection control, BLS and anaphylaxis and fire safety etc<br>• Locum pack<br>• Induction process in place?<br>• Immunisation, cervical screening samples training in place?<br>• Managing poor performance<br>• Appraisals in place? |

## Effective Staffing

| CQC REQUIREMENT | SUGGESTED EVIDENCE | PRACTICE EVIDENCE | LOCATION | OWNER | CQC MYTH BUSTER | COMPLETION STATUS |
|---|---|---|---|---|---|---|
| The registered person provided assurances that 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. | • Clinical Supervision audits<br>• Nurse revalidation | •<br>• | | | 4 / 56 / 70 | |
| The learning and development needs of staff were assessed | • Appraisals and action log | • | | | | |
| The provider had a programme of learning and development. | • Training Matrix | • | | | 70 | |
| There was an induction programme for new staff. This included completion of the Care Certificate for Health Care Assistants employed since April 2015. | • | • | | | 57 / 58 | |
| Staff had access to appraisals, one to one, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation | • Clinical Supervision audits<br>• Nurse revalidation | •<br>• | | | 4 / 56 / 70 | |
| The practice could demonstrate | • Audit | • | | | 4 / 56 / 70 / | |

| CQC REQUIREMENT | SUGGESTED EVIDENCE | PRACTICE EVIDENCE | LOCATION | OWNER | CQC MYTH BUSTER | COMPLETION STATUS |
|---|---|---|---|---|---|---|
| how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | • Appraisals | • | | | 81 / 82 | |
| | • Training<br>• Peer review | •<br>• | | | | |
| If no please explain below:<br>Add commentary here | | | | | | |
| Any further comments or notable training.<br>Add commentary here | | | | | | |

# Caring

## Kindness, Respect and Compassion

### CQC Comment Cards

| CQC COMMENTS CARDS | |
|---|---|
| Total comments cards received | |
| Number of CQC comments received which were positive about the service | |
| Number of comments cards received which were mixed about the service | |
| Number of CQC comments received which were negative about the service | |

### Examples of Feedback Received

| SOURCE | FEEDBACK |
|---|---|
| For example, comments cards, NHS Choices | • NHS choices – respond to all comments |
| | • Complaints |
| | • Social Media |
| | • PPG |

## National GP Survey Results

**Note**: The questions in the 2018 GP Survey indicators have changed. Ipos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology has changed in 2018. This means that we cannot be sure whether the change in scores was due to the change in methodology, or was due to a genuine change in patient experience.

| PRACTICE POPULATION SIZE | SURVEYS SENT OUT | SURVEYS RETURNED | SURVEY RESPONSE RATE% | % OF PRACTICE POPULATION |
|---|---|---|---|---|
| This will be populated by CQC | | | | |

| INDICATOR | PRACTICE | CCG AVERAGE | ENGLAND AVERAGE | ENGLAND COMPARISON |
|---|---|---|---|---|
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018) | | | 89.0% | |
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018) | | | 87.4% | |

| INDICATOR | PRACTICE | CCG AVERAGE | ENGLAND AVERAGE | ENGLAND COMPARISON |
|---|---|---|---|---|
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018) | | | 95.6% | |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018) | | | 83.8% | |
| Any additional evidence or comments | | | | |

## Practice Survey and Feedback

| CQC REQUIREMENT | SUGGESTED EVIDENCE | PRACTICE EVIDENCE | LOCATION | OWNER | CQC MYTH BUSTER | COMPLETION STATUS |
|---|---|---|---|---|---|---|
| The practice carries out its own patient survey/patient feedback exercises. | • Discussions on GP national survey results with PPG. | • | | | | |
| | • Healthwatch | • | | | | |
| | • Action Plans | • | | | | |
| | • Suggestion box | • | | | | |
| | • Internal surveys | • | | | | |

| DATE OF EXERCISE | SUMMARY OF RESULTS |
|---|---|
| PPG patient survey | Any Actions as a result of this and changes made |
| Friends and Family | Any Actions as a result of this and changes made |
| Any Additional Evidence | |

## Involvement in Decisions about Care and Treatment

| EXAMPLES OF FEEDBACK RECEIVED | |
|---|---|
| **SOURCE** | **FEEDBACK** |
| Interviews with patients | |

| INDICATOR | PRACTICE | CCG AVERAGE | ENGLAND AVERAGE | ENGLAND COMPARISON |
|---|---|---|---|---|
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018) | | | 93.5% | |
| Any additional evidence or comments | | | | |

## Language /Accessibility

| CQC REQUIREMENT | SUGGESTED EVIDENCE | PRACTICE EVIDENCE | LOCATION | OWNER | CQC MYTH BUSTER | COMPLETION STATUS |
|---|---|---|---|---|---|---|
| Interpretation services were available for patients who did not have English as a first language. | • Protocol for booking interpretation service | • | | | | |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations | • | • | | | | |
| Information leaflets were available in easy read format | • | • | | | | |
| Information about support groups was available on the practice website. | • Link to your website | • | | | | |

## Carers

| CARERS | NARRATIVE |
|---|---|
| Percentage and number of carers identified | |
| How the practice supports carers | • Carers award/Carers champion<br>• Carers pack<br>• Carers notice board<br>• Carers Health check<br>• Carers Coffee mornings<br>• Carers Policy<br>• Carers supporting evidence<br>• Flu vac for carers |

| CARERS | NARRATIVE |
|---|---|
| How the practice supports recently bereaved patients | • Bereavement Policy<br>• Do you send cards/visit patient or call them? |
| Any additional evidence or comments | |

## Privacy and Dignity

| PRIVACY AND DIGNITY | | | | | | |
|---|---|---|---|---|---|---|
| CQC REQUIREMENT | SUGGESTED EVIDENCE | PRACTICE EVIDENCE | LOCATION | OWNER | CQC MYTH BUSTER | COMPLETION STATUS |
| Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. | • Cleaning/changing schedule | • | | | | |

| QUESTION | Y/N |
|---|---|
| Arrangements to ensure confidentiality at the reception desk<br>• Signs in reception<br>• Confidential calls not made on front reception | |
| Consultation and treatment room doors were closed during consultations. | |
| A private room was available if patients were distressed or wanted to discuss sensitive issues. | |

| EXAMPLES OF FEEDBACK RECEIVED | |
|---|---|
| **SOURCE** | **FEEDBACK** |
| | |
| | |
| | |

# Responsive

## Responding to and Meeting People's Needs

### Practice Opening Times

| PRACTICE OPENING TIMES | | |
|---|---|---|
| **DAY** | **PRACTICE (INCLUDING EXTENDED HOURS)** | **DISPENSARY** |
| Monday | 8:00AM – 6:30PM | 8:30AM – 6:00PM |
| Tuesday | 8:00AM – 6:30PM | 8:30AM – 6:00PM |
| Wednesday | 8:00AM – 6:30PM (6:30PM – 7:45PM) | 8:30AM – 6:00PM |
| Thursday | 8:00AM – 6:30PM | 8:30AM – 6:00PM |
| Friday | 8:00AM – 6:30PM | 8:30AM – 6:00PM |
| Saturday | CLOSED | CLOSED |
| Sunday | CLOSED | CLOSED |

### Appointments Available (Core Hours)

| APPOINTMENTS AVAILABLE (CORE HOURS) |
|---|
| |

### Appointments Available (Extended Hours)

| APPOINTMENTS AVAILABLE (EXTENDED HOURS) |
|---|
| |

## Patient's Needs

| PATIENT'S NEEDS | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| Older People: | • Named GP?<br>• Home visits?<br>• Care home visits? | •<br>•<br>• | | | | |
| Long Term Conditions: | • Multiple conditions reviewed one appointment?<br>• Diabetes specialist nurse clinic?<br>• Liaison district nursing team?<br>• Record sharing | •<br>•<br>•<br>• | | | | |
| Families Children Young People: | • Follow up high A&E attendance.<br>• Appointment child same day offered? | •<br>• | | | | |
| Working Age Adults | • Telephone consultations<br>• Extended Hours<br>• Weekend appointments | •<br>•<br>• | | | | |

| PATIENT'S NEEDS | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| Vulnerable patients | • Able to register at practice? No fixed abode?<br>• Register?<br>• Transgender | • <br>• <br>• | | | | |
| Dementia/ mental health | • Good understanding?<br>• Specific clinics<br>• DNA follow up in place? | • <br>• <br>• | | | | |
| The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. | • Home Visiting Policy | • | | | | |
| If yes, describe how this was done.<br>• Ensure non-clinical staff are not making decisions that should be made by a clinician.<br>• Ensure patients with highest clinical need are prioritised and no delay in being seen. | | | | | | |

## Population

| PRACTICE POPULATION SIZE | SURVEYS SENT OUT | SURVEYS RETURNED | SURVEY RESPONSE RATE% | % OF PRACTICE POPULATION |
|---|---|---|---|---|
| | | | | 0.8% |

| INDICATOR | PRACTICE | CCG AVERAGE | ENGLAND AVERAGE | ENGLAND COMPARISON |
|---|---|---|---|---|
| The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018) | | | | 94.8% |
| Any additional evidence or comments | | | | |

## Timely Access to the Service

| NATIONAL GP SURVEY RESULTS | | | | |
|---|---|---|---|---|
| **INDICATOR** | **PRACTICE** | **CCG AVERAGE** | **ENGLAND AVERAGE** | **ENGLAND COMPARISON** |
| 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 (01/01/2018 to 31/03/2018) | | | 70.3% | |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018) | | | 68.6% | |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018) | | | 65.9% | |
| The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018) | | | 74.4% | |

| NATIONAL GP SURVEY RESULTS | | | | |
|---|---|---|---|---|
| **INDICATOR** | **PRACTICE** | **CCG AVERAGE** | **ENGLAND AVERAGE** | **ENGLAND COMPARISON** |
| Any additional evidence or comments | | | | |

## Examples of Feedback Received from Patients

| EXAMPLES OF FEEDBACK RECEIVED FROM PATIENTS | |
|---|---|
| **SOURCE** | **FEEDBACK** |
| For example i.e. NHS Choices | |
| Social Media | |
| Complaints | |
| Survey | |
| Healthwatch | |
| Other | |

## Listening and Learning from Complaints Received

| COMPLAINTS | |
|---|---|
| Number of complaints received in the last year. | |
| Number of complaints we examined | |
| Number of complaints we examined that were satisfactorily handled in a timely way | |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman | |

| ADDITIONAL COMMENTS |
|---|
| |

| EXAMPLE OF HOW QUALITY HAS IMPROVED IN RESPONSE TO COMPLAINTS |
|---|
| |

| ANY ADDITIONAL EVIDENCE |
|---|
| • Complaints leaflet<br>• Complaint summary for year<br>• Minutes from meetings where complaints have been discussed |

# Well-led

## Leadership Capacity and Capability

### Examples of how Leadership, Capacity and Capability were Demonstrated by the Practice

| EXAMPLES OF HOW LEADERSHIP, CAPACITY AND CAPABILITY WERE DEMONSTRATED BY THE PRACTICE | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| What is the practice strategy? | • Business Development Plan<br>• 5 year plan<br>• Performance audits<br>• Appraisals including for salaried GPs | •<br>•<br>•<br>• | | | 48 | |
| How is it shared with staff and is it being delivered? | • Minutes of meeting<br>• Used of intranets<br>• Handbooks | •<br>•<br>• | | | | |
| Do leaders have capacity, skills and experience to deliver? | • | • | | | | |
| Is it in line with health and social care priorities? | • | • | | | | |
| Risk action plan in place and delivered. How monitored? | • | • | | | | |
| Any additional evidence | | | | | | |

## Vision and Strategy

| PRACTICE VISION AND VALUES | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| What are the values/aims? | • Business Development Plan<br>• 5 year plan | •<br>• | | | | |
| Are staff aware of the values? | • | • | | | | |
| How were they communicated? | • | • | | | | |
| Does the business plan support the values? | • | • | | | | |

## Culture

| EXAMPLES THAT DEMONSTRATE THAT THE PRACTICE HAS A CULTURE OF HIGH-QUALITY SUSTAINABLE CARE | | | | | | |
|---|---|---|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **PRACTICE EVIDENCE** | **LOCATION** | **OWNER** | **CQC MYTH BUSTER** | **COMPLETION STATUS** |
| Do staff report feeling supported? | • | • | | | | |
| Openness and honesty SEA, meet requirements of duty of candour? | • | • | | | | |
| Clinical staff have time for professional development and for clinical management and governance. | • | • | | | | |

## Examples of Feedback from Staff or other Evidence about Working at the Practice

| EXAMPLES OF FEEDBACK FROM STAFF OR OTHER EVIDENCE ABOUT WORKING AT THE PRACTICE | |
|---|---|
| **SOURCE** | **FEEDBACK** |
| | |
| | |
| | |
| | |
| Any additional evidence | |

## Governance Arrangements

| EXAMPLES OF STRUCTURES, PROCESSES AND SYSTEMS IN PLACE TO SUPPORT THE DELIVERY OF GOOD QUALITY AND SUSTAINABLE CARE | | |
|---|---|---|
| Practice specific policies | • Are they easily accessible?<br>• Do staff know how to access them?<br>• Who reviews them | |
| Other examples | • <br>• <br>• <br>• | |
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **Y/N** |
| Staff were able to describe the governance arrangements | • Who the leads for each area are<br>• Where the policies are kept | |
| Staff were clear on their roles and responsibilities | • CQC will ask this in the day | |
| Any additional evidence | | |

## Managing Risks, Issues and Performance

| MAJOR INCIDENT PLANNING | | | |
|---|---|---|---|
| **CQC REQUIREMENT** | **SUGGESTED EVIDENCE** | **CQC MYTH BUSTER** | **Y/N** |
| Major incident plan in place | • Business continuity plan with risk measured | 63 / 69 | |
| Staff trained in preparation for major incident | • Training on business continuity plan | | |

| EXAMPLES OF ACTIONS TAKEN TO ADDRESS RISKS IDENTIFIED WITHIN THE PRACTICE | |
|---|---|
| **RISK** | **EXAMPLE OF RISK MANAGEMENT ACTIVITIES** |
| | |
| | |
| | |
| | |
| | |
| | |
| Any additional evidence | |

| APPROPRIATE AND ACCURATE INFORMATION | | |
|---|---|---|
| **QUESTION** | **SUGGESTED EVIDENCE** | **Y/N** |
| Staff whose responsibilities include making statutory notifications understood what this entails | • Make yourself familiar with what is reportable and where (CQC MYTH 63)<br>• Controlled drug officer<br>• NHSE<br>• CCQ<br>• CQC<br>• FGM<br>• IG toolkit<br>• ICO<br>• Infectious diseases<br>• MHRA<br>• NPSA<br>• RIDDOR<br>• Safeguarding<br>• NHS fraud<br>• Imms and Vaccs team | |
| Any additional evidence | | |

## Engagement with Patients, the Public, Staff and External Partners

| FEEDBACK FROM PATIENT PARTICIPATION GROUP |
| --- |
| **FEEDBACK** |
| |
| **ANY ADDITIONAL EVIDENCE** |
| Patient newsletter? |

## Continuous Improvement and Innovation

| EXAMPLES OF IMPROVEMENTS DEMONSTRATED AS A RESULT OF CLINICAL AUDITS IN PAST TWO YEARS | |
|---|---|
| **AUDIT AREA** | **IMPROVEMENT** |
| | |
| | |
| | |
| | |
| | |
| | |
| Any additional evidence | |

# 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 comparable, 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 comparable 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 Band | Z-score threshold |
|---|---|---|
| 1 | Significant variation (positive) | $Z \leq -3$ |
| 2 | Variation (positive) | $-3 < Z \leq -2$ |
| 3 | Comparable to other practices | $-2 < Z < 2$ |
| 4 | Variation (negative) | $2 \leq Z < 3$ |
| 5 | Significant variation (negative) | $Z \geq 3$ |
| 6 | No data | Null |

**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.

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: http://www.cqc.org.uk/what-we-do/how-we-use-**information/monitoring-gp-practices**

Glossary of terms used in the data.

- COPD: Chronic Obstructive Pulmonary Disease
- PHE: Public Health England
- QOF: Quality and Outcomes Framework (see https://qof.digital.nhs.uk/).
- RCP: Royal College of Physicians.
- 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.( See NHS Choices for more details).

# Disclaimer

Although Lincolnshire Local Medical Committee Limited has gone to great lengths to ensure that all information contained in this document is accurate at the time of publication, inaccuracies & typographical errors may occur. Lincolnshire Local Medical Committee Limited does not warrant or guarantee the accuracy or completeness of the information provided in this document. We can accept no responsibility or liability, which may arise from the use of information published in this presentation. Under no circumstances will Lincolnshire Local Medical Committee Limited be liable for any loss or direct, indirect, incidental, special or consequential damages caused by the reliance of information in this document.