

# Care Quality Commission

## Inspection Evidence Table

**Dr Sunita Bhalchandra Kulkarni (1-503863723)**

Inspection date: 6 February 2019

Date of data download: 23 January 2019

## Overall rating: add overall rating here

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

## Safe Rating: Requires improvement

The practice is rated as requires improvement for providing a safe service. This is because:

- Not all staff had received safeguarding training at appropriate levels for their role.
- An effective employee immunisation programme was not in place.
- Fire drills had not been completed within the health centre since 2017. The practice had not initiated any fire drills amongst their own staff in the absence of a whole premises fire drill.
- Regular reviews of a practice nurse's prescribing had not been completed.
- A system was not in place to prevent the accidental interruption of the electrical supply to the vaccine refrigerator. This had been a recommendation at our previous inspection in 2014.

### Safety systems and processes

**The practice had systems, practices and processes to keep people safe and safeguarded from abuse however they were not always effective.**

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 vulnerable adult and child safeguarding.	Y*
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	P*
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	P**
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y

Safeguarding	Y/N/Partial
There was a risk register of specific patients.	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, 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 policy for safeguarding vulnerable adults did not reflect all categories of abuse. For example, human trafficking, modern slavery and female genital mutilation. Following our inspection, the practice forwarded to us an updated policy.

\*\*At our previous inspection in November 2014 a recommendation was made that staff should attain the appropriate level of training in safeguarding vulnerable adults and children. At this inspection we found that an effective system for monitoring staff compliance with essential training was not in place. We reviewed staff files and identified that GPs and practice nurses had completed safeguarding training to the appropriate level for their role. However, there were no records to demonstrate that four receptionists had completed training in safeguarding vulnerable adults or that two receptionists had completed training in safeguarding children. A health care assistant and a practice nurse completed safeguarding training on the day of our inspection.

\*\*\*We reviewed the records of six members of staff. We found that DBS checks had not been completed for two reception staff. Risk assessments had been carried out to mitigate potential risks to patients.

Posters informing patients of their right for a chaperone during intimate examinations were not clearly displayed throughout the practice. Following our inspection, we received confirmation from the practice that posters were now on display in all clinical rooms and within the reception area.

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 and if relevant to role.	P*
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff had any necessary medical indemnity insurance.	Y
Explanation of any answers and additional evidence:	
* An effective employee immunisation programme was not in place. Evidence that staff were up to date with their routine immunisations, for example tetanus, polio, diphtheria, measles, mumps and rubella (MMR) was not available for most staff. Following our inspection, the practice informed us that they would carry out a review of staff immunisation and immunity. We will review this at our next inspection. Risk assessments had not been completed to mitigate risks to staff and patients in the absence of immunity to hepatitis B for non-clinical staff that were not provided with immunisation against hepatitis B.	

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:	Y 31 January 2019
There was a record of equipment calibration. Date of last calibration:	Y 31 January 2019
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check:	Y April 2018
There was a log of fire drills. Date of last drill:	Y 13 June 2017*
There was a record of fire alarm checks. Date of last check:	Y 23 January 2019
There was a record of fire training for staff.	Y
There were fire marshals. Date of last training:	Y 31 January 2019
A fire risk assessment had been completed. Date of completion:	Y 9 November 2015**
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>*Fire drills had not been completed within the health centre since 2017. The practice had not initiated any fire drills amongst their own staff in the absence of a whole premises fire drill. However, there was evidence that false fire alarms had occurred in 2018 and 2019 and evacuation procedures appropriately followed.</p> <p>**The fire risk assessment related to the whole of the health centre. There was a recommendation within the fire risk assessment that it is updated in November 2020. The practice had completed a fire risk assessment for their own practice on 1 February 2019.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Y 13 September

	2016
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	P* 30 September 2016
Explanation of any answers and additional evidence: *An emergency lighting test had been completed on 16 January 2019. * Documents we reviewed showed that a legionella risk assessment had not been carried out since 2013. However, we saw that regular testing for legionella had been carried out. Control of Substances Hazardous to Health (COSHH) risk assessments had not been reviewed since 2013. Following our inspection, the practice forwarded to us evidence that they had contacted the landlord of the premises requesting the most up to date legionella risk assessment and COSHH risk assessments.	

### Infection prevention and control

#### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit:	9 February 2018
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: Completed cleaning schedules were available in clinical rooms and throughout the building.	

### Risks to patients

#### There were 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
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	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
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

### 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.	Y
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
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

## Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation.

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) (01/10/2017 to 30/09/2018) <small>NHS Business Service Authority - NHSBSA</small>	1.09	1.02	0.94	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). (01/10/2017 to 30/09/2018) <small>(NHSBSA)</small>	3.6%	6.8%	8.7%	Variation (positive)

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 (PGD) 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.	N**
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 changes to a patient's medicines including changes made by other services.	Y
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
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.	Y

Medicines management	Y/N/Partial
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
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	P****
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y*****
<p>Explanation of any answers and additional evidence:</p> <p>*On the day of our inspection we found that three PGDs had expired in 2018. These were updated with the current PGDs on the day of our inspection.</p> <p>**A practice nurse was a nurse prescriber. They told us they could approach the GP with queries and for support. However, a regular review of their prescribing practice had not been completed by the practice. Following our inspection, the practice forwarded to us a 'Practice Statement for Supervision of Nurse Prescribing' to demonstrate how they will review future nurse prescribing. We will review the effectiveness of this at our next inspection.</p> <p>***The practice was proactive in managing their prescribing of antimicrobial medicines. The 3.6% prescribing rate for co-amoxiclav, cephalosporins and quinolones was below the local and national average.</p> <p>****There was a system in place for the monthly checking of the oxygen cylinder. Records showed that the oxygen had been checked in January 2019. However, on the day of our inspection we found that the oxygen cylinder was empty. The oxygen had not been used since the check in January and the practice were unable to explain why it was empty. They ordered a replacement cylinder on the day of our inspection. Following our inspection, the practice forwarded to us a completed significant event analysis and the learning from the incident.</p> <p>*****At our previous inspection in 2014, we made a recommendation to install a switchless socket or clearly label the vaccine refrigerator plug with a cautionary notice to reduce the possibility of accidental interruption of the electrical supply to the vaccine refrigerator. At this inspection we saw this had not been completed.</p>	

## Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong.

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.	Y
Number of events recorded in last 12 months:	5
Number of events that required action:	5

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
There were insufficient flu vaccinations needed for patients registered with the practice.	When the stock of vaccinations became very low, patients were prioritised. To meet the demand for the remaining patients the practice borrowed vaccines from other practices and directed patients to local pharmacies. As a result of this significant event, the practice identified the need to assess the demand for flu vaccines earlier in subsequent years to ensure they have an adequate supply.
A GP admitted an apparently ill patient and their companion into the health centre after the practice had closed. The GP and a domestic cleaner were alone with the couple in the building. The couple became verbally aggressive and agitated.	The police were called however the couple were unable to be found when they arrived. As a result of this significant event, the practice reviewed their lone worker and security policy. They liaised with the primary care trust to ensure staff from the GP practice and staff employed to work in the health care centre worked together. A recommendation was made to ensure that a minimum of two staff members left the health centre together.

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



## Effective

## Rating: Good

We rated all of the populations groups as good for effective apart from patients experiencing poor mental health which we rated as outstanding. This was because:

- The practice had developed and configured an assessment framework template and risk assessment within their computer system to ensure National Institute for Clinical Excellence (NICE) guidelines were followed for patients at risk of suicide or self-harm. The local clinical commissioning group (CCG) asked the practice to share these tools with other practices in the CCG as an example of good practice.

### Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment were 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
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 were in place 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

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) (01/10/2017 to 30/09/2018) <small>(NHSBSA)</small>	1.43	0.91	0.81	No statistical variation

### Older people

### Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>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.</li> <li>The practice followed up older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.</li> <li>Staff had appropriate knowledge of treating older people including their psychological, mental and</li> </ul>

communication needs.

- Annual health reviews were offered to patients over 75 years of age and care plans updated as required. We spoke with the managers of two care homes. They told us that the practice was proactive in offering and providing annual health reviews to their residents. They told us that the practice nurses visited the care homes to carry out the reviews.
- Clinical staff provided domiciliary flu immunisations for older patients who were housebound or unable to attend the practice.
- There was a system in place to follow up patients with diabetes who failed to attend for retinoscopy screening.

## People with long-term conditions

## Population group rating: Good

### Findings

- Patients with long-term conditions had a structured annual review to check their health and medicine 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.
- Alerts were set up within the practice's computer system for patients prescribed medicines that required regular blood monitoring. This ensured that blood sampling and reviewing were completed within recommended timeframes.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs 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 atrial fibrillation were assessed for stroke risk and treated appropriately. Audits had been completed to ensure that this group of patients had a clear diagnosis and up-to-date blood monitoring.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	85.5%	74.5%	78.8%	No statistical variation
Exception rate (number of exceptions).	21.5% (17)	9.6%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	90.3%	75.4%	77.7%	No statistical variation
Exception rate (number of exceptions).	8.9% (7)	7.5%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	94.4%	80.2%	80.1%	Variation (positive)
Exception rate (number of exceptions).	8.9% (7)	11.8%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small>	88.6%	77.8%	76.0%	Variation (positive)
Exception rate (number of exceptions).	2.4% (3)	5.2%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	95.6%	88.6%	89.7%	No statistical variation
Exception rate (number of exceptions).	15.1% (8)	9.8%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	86.7%	81.8%	82.6%	No statistical variation
Exception rate (number of exceptions).	0.4% (1)	3.2%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) <small>(QOF)</small>	100.0%	91.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	16.7% (2)	5.1%	6.7%	N/A

### Any additional evidence or comments

The practice had a higher than average exception rate for several of the quality indicators for patients with long-term conditions. We discussed this with the GP who explained this was due to the low number of patients which skewed the figures.

The practice had achieved above the CCG and national averages for several of the key indicators for patients with long-term conditions. Specifically, patients with diabetes, asthma, COPD and atrial fibrillation.

### Families, children and young people

### Population group rating: Good

#### Findings

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets for children over one year old. However, 2017/18 data from NHS England showed they were below the 90% target for children aged one year and under. We discussed this with the practice nurse. They showed us evidence that all of these children were now up to date with their immunisations and there were no children, aged one and under, overdue immunisation.
- 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 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.
- Young people could access services for sexual health and contraception at the practice. Alerts were added to patients' records to prompt clinicians to offer opportunistic chlamydia advice and testing where appropriate.

Child Immunisation	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) (01/04/2017 to 31/03/2018) <small>(NHS England)</small>	12	15	80.0%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) <small>(NHS England)</small>	13	13	100.0%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their immunisation for	13	13	100.0%	Met 95% WHO based target (significant

Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)				variation positive)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	13	13	100.0%	Met 95% WHO based target (significant variation positive)

## Working age people (including those recently retired and students)

Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>The practice had systems in place to invite eligible patients for the meningitis vaccine, for example before attending university for the first time. A dedicated staff member was responsible for identifying and contacting patients who were eligible for this vaccine.</li> <li>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.</li> <li>Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.</li> </ul>

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)	67.9%*	70.5%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	73.4%	71.3%	70.0%	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)	45.2%**	53.0%	54.5%	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)	75.0%	72.0%	70.3%	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)	62.5%	59.8%	51.9%	No statistical variation

### Any additional evidence or comments

\*The practice had not achieved the target rate of 80% for cervical screening. We discussed this with the practice nurse who told us several groups of patients were reluctant to engage with the cervical screening programme. To increase the uptake of the service, alerts were added to the records of this group of patients to promote opportunistic screening when they attended for other issues. The practice nurse also provided pre-screening education appointments and easy read literature for patients with a learning disability who required cervical screening.

\*\*The practice's percentage for screening patients aged 60-69 years for bowel cancer was below the CCG and national average. To address this issue the practice had added a prompt to their website encouraging eligible patients to comply with bowel screening. They also telephoned patients who had not participated in this screening to explain why it was important.

### People whose circumstances make them vulnerable

Population group rating: **Good**

#### Findings

- End of life care was delivered in a coordinated way which considered the needs and wishes of those whose circumstances may make them vulnerable.
- Where possible, the practice supported patients receiving end of life care to die where they wished to. Nine patients out of 19 patients who died last year had been supported to die in their own home or residential setting.
- The practice held a register of patients living in vulnerable circumstances including homeless people, carers, patients at risk of suicide, those recently discharged from prison and those with a learning disability.
- 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 health care assistant carried out targeted health assessments for patients who were carers.

### People experiencing poor mental health (including people with dementia)

Population group rating: **Outstanding**

#### 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.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- The practice discussed patients at risk with the local access team and where required, appropriate support was put in place. For example, referrals to other services, home treatment and a team review.
- 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. The managers of two care homes we spoke with told us that the practice actively involved the families

of residents with dementia in decisions about their care.

- Some staff had received dementia training in the last 12 months.
- The practice had developed and configured an assessment framework template and risk assessment within their computer system to ensure NICE guidelines were followed for patients at risk of suicide or self-harm. 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. The practice carried out two-yearly audits of patients who had attempted suicide and staff had received suicide prevention training. The local CCG asked the practice to share their risk assessment and assessment framework with other practices in the CCG as an example of good practice.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	100.0%	84.9%	89.5%	No statistical variation
Exception rate (number of exceptions).	12.5% (1)	9.1%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	100.0%	89.5%	90.0%	No statistical variation
Exception rate (number of exceptions).	12.5% (1)	7.9%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	100.0%	79.5%	83.0%	Variation (positive)
Exception rate (number of exceptions).	16.7% (2)	7.0%	6.6%	N/A

#### Any additional evidence or comments

Mental health quality indicators for the practice were above the CCG and national averages. However, their exception reporting was higher than the CCG and national averages. The GP told us this was due to the small number patients within this population group that were registered with the practice.

## 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)	559.0	535.2	537.5
Overall QOF exception reporting (all domains)	7.0%	5.5%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y

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

<p>The practice had a detailed programme of quality improvement audits they had carried out over the previous four years. It included the outcome of audits completed, the action taken and plans for future re-audits. We saw that six audits had been completed in 2018. Examples of these included:</p> <ul style="list-style-type: none"> <li>In response to a Medicines and Healthcare products Regulatory Agency (MHRA) alert in October 2018, the practice carried out an audit to ensure that patients prescribed direct oral anticoagulant (DOAC) medicines had a diagnosis and up-to-date blood monitoring. This was to ensure that the prescribing of DOAC medicines was correct. A computer search identified 22 patients prescribed DOAC medicines. Two patients did not have a recorded diagnosis and nine patients were not up to date with the required blood monitoring. In addition, eight patients did not have a documented, up-to-date weight. The appropriate action was taken by the practice to address the outstanding information. In addition, the practice developed a template to record a patient's weight, diagnosis and blood monitoring history. The template included a status alert and a quick action button to enable GPs to easily access the latest blood results. A system was also developed to provide regular oversight of the status of patients prescribed DOAC medicines.</li> <li>The practice was proactive in supporting patients who attempted suicide. The practice carried out two-yearly audits of patients who had attempted suicide and reflected on the care provided to these patients to ensure that it was in line with National Institute for Clinical Excellence (NICE) guidelines. In response to this, the practice developed an assessment framework to ensure guidelines were followed. Risk assessments were also carried out to determine the level of a patient's risk and training provided to staff. As a result of this work, the local clinical commissioning group (CCG) asked the practice to share their templates and assessment framework with other practices in the CCG as an example of good practice.</li> </ul>
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## Effective staffing

**The practice was unable to demonstrate that all 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.	P*
Staff had protected time for learning and development.	P**
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, and mentoring. 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.	N***
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y****
<p>Explanation of any answers and additional evidence:</p> <p>*Staff were supported to attend development training. However, systems for ensuring mandatory training was completed were not in place.</p> <p>**Staff were not always provided with protected learning time to support them to complete their training. We were told that staff had completed recent online training at home in their own time.</p> <p>***One of the practice nurses was also a nurse prescriber. They told us they could approach the GP with queries and for support. However, a regular review of their prescribing practice had not been completed by the practice.</p> <p>****We saw an example of when poor staff performance had been identified by the practice and appropriate processes had been followed to address it.</p>	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

## 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
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

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	98.7%*	95.9%	95.1%	Variation (positive)
Exception rate (number of exceptions).	0 (0)	0.6%	0.8%	N/A

### Any additional evidence or comments

\*The practice's smoking indicators were above the CCG and national averages. The practice offered an in-house smoking cessation service to their patients.

### 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
Explanation of any answers and additional evidence: We saw that there was a process in place for obtaining consent for childhood immunisations. Clinical staff we spoke with understood the requirements of the mental capacity act however, it was not clear if they had completed training in this area. One of the practice nurses completed the training on the day of our inspection.	

# Caring

**Rating: Good**

## Kindness, respect and compassion

**Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.**

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

CQC comments cards	
Total comments cards received.	20
Number of CQC comments received which were positive about the service.	19
Number of comments cards received which were mixed about the service.	1
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC comment cards.	Patients told us that staff were professional, friendly, helpful and caring. Many commented that the practice provided an excellent, personal service.

## National GP Survey results

**Note:** The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
1226	289	91	31.5%	7.42%

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	90.5%	88.4%	89.0%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)				
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)	87.3%	86.5%	87.4%	No statistical variation
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)	94.0%	94.9%	95.6%	No statistical variation
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)	90.5%	83.1%	83.8%	No statistical variation

**Any additional evidence or comments**

Prior to our inspection we spoke with the managers of two care homes where the practice provided care and treatment to patients living there. They told us that the practice was very supportive to their patients and listened to their needs.

Question	Y/N
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The practice carries out its own patient survey/patient feedback exercises.	Y
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**Any additional evidence**

The practice collected patient feedback through the Friends and Family Test. In 2018 the practice had received 310 replies:

- 272 patients replied they were extremely likely to recommend the service to their friends and family.
- 28 patients were likely.
- Eight were neither likely or unlikely.
- Two were unlikely.

## Involvement in decisions about care and treatment

### Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

Source	Feedback
NHS Choices.	One patient commented positively that the practice nurse involved them in decisions about their care and provided adequate time during consultations. They commented that the service was designed to meet their needs and not the needs of the practice.

## National GP Survey results

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)	94.7%	92.0%	93.5%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	P*
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: *Easy read leaflets were available regarding cervical screening.	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 30 patients as carers which was 2.4% of the practice patient list.

How the practice supported carers.	The practice offered patients who were carers regular health care assessments and flu immunisations.
How the practice supported recently bereaved patients.	There was information on the practice's website providing advice to patients on the actions to take in times of bereavement. When the practice was aware that a patient had suffered a bereavement, they called the patient to offer support and provided home visits were required.

## Privacy and dignity

### The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

## Responsive

**Rating: Good**

We rated all of the population groups as good for providing a responsive service.

### Responding to and meeting people's needs

**The practice organised and delivered services to meet patients' needs.**

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y

Practice Opening Times	
Day	Time
<b>Opening times:</b>	
Monday	8am – 1pm and 2pm – 6.30pm
Tuesday	8am – 1pm and 2pm – 6.30pm
Wednesday	8am – 1pm and 2pm – 6.30pm
Thursday	8am – 2pm
Friday	8am – 1pm and 2pm – 6.30pm
<b>Appointments available:</b>	
Monday	9.30am – 11.30am and 5pm – 6pm
Tuesday	9.30am – 11.30am and 5pm – 6pm
Wednesday	10.40am – 12pm and 5pm – 6pm
Thursday	9.30am – 12pm
Friday	9.30am – 12pm and 5pm – 6pm

#### Extended hours opening:

Were provided by the North Staffordshire GP Federation Extended Hours Primary Care Services Programme: Monday to Friday 4pm to 8pm and Saturday and Sunday 10am to 1pm at five locations:

- Hanley Primary Care Access Centre ST1 1LW
- Haywood Hospital ST6 7AG
- Bradwell Community Hospital ST5 7NU
- Longton Cottage Hospital, ST3 4QX
- Leek Moorlands Hospital ST13 5BQ



## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
1226	289	91	31.5%	7.42%

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)	92.3%	93.9%	94.8%	No statistical variation

### Any additional evidence or comments

There was one negative comment on a CQC comment card stating a patient did not feel the practice understood their needs.

### Older people

### Population group rating: Good

#### Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- Prior to our inspection we spoke with the managers of two care homes where the practice provided care and treatment to patients living there. They told us the practice customised the service they offered to meet the specific needs of their patients.
- If older patients attended the practice on a day the phlebotomy service was not available, a qualified member of staff took their blood sample to avoid the patient making a return visit.

### People with long-term conditions

### Population group rating: Good

#### Findings

- Patients with multiple conditions had their needs reviewed in one appointment if it was appropriate to do so.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

## **Families, children and young people**

**Population group rating: Good**

### **Findings**

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- A practice nurse provided Contraception and Sexual Health (CASH) reviews at the practice.

## **Working age people (including those recently retired and students)**

**Population group rating: Good**

### **Findings**

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, online booking of appointments and ordering of repeat prescriptions.
- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available Saturday and Sunday 10am until 1pm.
- When safe to do so, the practice issued longer repeat prescriptions for working patients with stable medicine regimes to prevent the need for monthly visits to the practice.

## **People whose circumstances make them vulnerable**

**Population group rating: Good**

### **Findings**

- The practice held a register of patients living in vulnerable circumstances including homeless people, carers, those recently discharged from prison and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

## People experiencing poor mental health Population group rating: Good (including people with dementia)

### Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health. Reception staff were aware of patients experiencing poor mental health and provided open access to clinical staff for this group of patients to ensure their needs were met quickly.
- Staff interviewed had a good understanding of how to support patients experiencing poor mental health and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- The practice had developed and configured an assessment framework template and risk assessment within their computer system to identify and support patients at risk of suicide or self-harm. 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.

### Timely access to the service

#### People were able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y

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)	96.2%*	N/A	70.3%	Significant Variation (positive)
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)	91.6%*	68.5%	68.6%	No statistical variation
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)	86.6%*	68.7%	65.9%	No statistical variation
The percentage of respondents to the GP	93.0%*	76.1%	74.4%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)				

Any additional evidence or comments
*All of the key indicators relating to access to appointments were above the CCG and national average.

Source	Feedback
Care homes	Prior to our inspection we spoke with the managers of the two care homes where the practice provided care and treatment. They told us that the practice was always responsive to their request for home visits for patients living in the home.
CQC cards comment	Patients told us they could easily access appointments at the practice.

### Listening and learning from concerns and complaints

### Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	4
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y*
There was evidence that complaints were used to drive continuous improvement.	Y**
Explanation of any answers and additional evidence: * Information about how to make a complaint or raise concerns was available on the practice's website. There were complaints leaflets at the practice for patients to refer to however, they were not readily accessible. Following our inspection, the practice forwarded evidence to us demonstrating they were readily accessible to patients on the reception desk. ** The practice recorded, investigated and shared learning from verbal and written complaints. Minutes showed that the practice carried out an annual review of complaints to identify any trends.	

Example of learning from complaints.

Complaint	Specific action taken
A patient believed they had been prescribed an incorrect combination of medicines.	A meeting was arranged between the patient and prescribing GP. An explanation was provided to the patient regarding the rationale for the medicines prescribed. The GP apologised that the patient did not feel they had been prescribed the correct medicines. The patient accepted the apology and explanation however decided to register with a different practice.

## Well-led

## Rating: Requires improvement

**We rated the practice as requires improvement for well-led. This was because:**

- Governance arrangements to ensure staff compliance with training were ineffective.
- All of the recommendations made at our previous inspection in November 2014 had not been actioned.
- Several policies referred to by staff to support the governance of processes and systems at the practice had not been reviewed since 2014.
- The practice had not submitted a notification to the Care Quality Commission as required under the Care Quality Commission (Registration) Regulations 2009.

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y*
Explanation of any answers and additional evidence: *The lead GP planned to retire in the near future. We saw that there was succession planning in place to ensure continuity of care for patients.	

### Vision and strategy

**The practice had a clear vision and credible strategy to provide high quality sustainable care.**

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
<b><u>The practice's mission statement and vision were:</u></b>	
<b>Mission Statement</b>	
To improve the health, well-being and lives of those we care for.	

## Vision

To work in partnership with our patients and staff to provide the best primary care services possible working within local and national governance, guidance and regulations.

## 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
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
Explanation of any answers and additional evidence: *We saw that when risks to the safety of staff were identified, analysis of the event was completed and learning used to mitigate risks to future staff safety.	

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

Source	Feedback
Interviews with staff	Staff told us there was an open and transparent culture within the practice. They told us that they felt confident to raise any concerns with both the management team and within team meetings and that their concerns would be listened to.

## Governance arrangements

### There were clear responsibilities and roles of accountability to support good governance and management. However, governance systems were not always effective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	P*
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: *Governance arrangements to ensure staff compliance with training were ineffective. There was no overarching system in place to monitor training completed or training that needed to be completed. We were shown a list of mandatory training as identified by the practice. However, it was not role specific. For example, it showed that training for safeguarding children, level three, was required to be completed	

every 12 months. However, it did not clarify which members of staff required this higher level of training. Recommendations made at our previous inspection in November 2014, that all staff should complete safeguarding training appropriate to their role, had not been fully actioned. Staff that had completed it did so in the weeks leading up to this inspection or on the day of the inspection. From our examination of staff records, we found that four staff members had not completed training in safeguarding vulnerable adults. We found other gaps in training, for example, basic life support.

\*There were policies in place to support the governance of processes and systems at the practice. However, staff told us they referred to both online policies and a folder that contained paper copies of the policies. We saw that many of the paper policies had not been reviewed since 2014. The practice told us the on-line policies had been reviewed more recently. This caused confusion amongst staff regarding which policies to refer to. For example, some staff showed us the paper policy for safeguarding vulnerable adults that had been reviewed in 2014. Other staff showed us the online policy for safeguarding vulnerable adults that had been reviewed in 2018.

## 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.	P**
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: *A business continuity plan was in place however, it did not contain appropriate contact numbers for services or staff. **There was no evidence to demonstrate that three members of non-clinical staff had completed training in basic life support.	



## 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.	N*
Explanation of any answers and additional evidence:  *We reviewed the significant events and saw that an incident had occurred at the practice requiring the police to be called. The practice had not submitted a notification to the Care Quality Commission as required under the Care Quality Commission (Registration) Regulations 2009.	

## Engagement with patients, the public, staff and external partners

**The practice involved the public, staff and external partners to sustain high quality and sustainable care.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
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 and the patient participation group (PPG) were working with NHS England, Midlands Partnership NHS Foundation Trust and the local Member of Parliament to address the issue of the increased demand on the practice due to a shortage of reception staff working within the health centre.	

Feedback from Patient Participation Group.

Feedback
Prior to our inspection we spoke with a member of the PPG. They informed us several patients had left the PPG in September 2018 so meetings with the practice had decreased. The remaining PPG members were working with the practice to increase patient membership. They told us the practice was very responsive to their suggestions and tailored the service to meet the needs of the practice population. They also told us that the practice listened and acted on concerns raised by the PPG. For example, the PPG had expressed concerns regarding the small size of the consultation rooms and restricted access to patients with wheelchairs. In response to this, the rooms had been reconfigured to provide more space and improved access for those with impaired mobility.

## Continuous improvement and innovation

### There were systems and processes for 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

- A health care support worker had been supported to work as an elderly care facilitator to ensure that the needs of older patients were being met.
- The GP had carried out a 360-degree audit of their performance with patients and colleagues. Twenty-five questionnaires were given to patients and 25 to colleagues. The feedback was mostly positive highlighting good areas of practice such as clinical decision making, record keeping, knowledge and skills. Feedback highlighted one area of improvement regarding the supervising of colleagues. The GP was considering how, as a single-handed GP, they could make improvements in this area.
- The practice had developed and configured an assessment framework template and risk assessment to support patients at risk of suicide or self-harm. The local clinical commissioning group (CCG) asked the practice to share their risk assessment and assessment framework with other practices in the CCG as an example of good practice.

## 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 practice's 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 Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	No statistical variation	$-2 < Z < 2$
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.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:  
<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

### Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.