

Care Quality Commission

Inspection Evidence Table

Brewood Surgery (1-2723768267)

Inspection date: 6 February 2019

Date of data download: 31 January 2019

Overall rating: add overall rating here

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

Safe

Rating: Good

Safety systems and processes

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

| Safeguarding | Y/N/Partial |
|--|-------------|
| There was a lead member of staff for safeguarding processes and procedures. | Yes |
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Yes |
| There were policies covering adult and child safeguarding. | Yes |
| Policies took account of patients accessing any online services. | Yes |
| Policies and procedures were monitored, reviewed and updated. | Yes |
| Policies were accessible to all staff. | Yes |
| Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs). | Yes |
| There was active and appropriate engagement in local safeguarding processes. | Yes |
| There were systems to identify vulnerable patients on record. | Yes |
| There was a risk register of specific patients. | Yes |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Partial |
| Staff who acted as chaperones were trained for their role. | Yes |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Yes |
| Explanation of any answers and additional evidence: The practice was part of a locality pilot for an online self-help app (application). There was no record of the risk assessment for the driver the practice | |

| Safeguarding | Y/N/Partial |
|-------------------------------|-------------|
| assured us this was in place. | |

| Recruitment systems | Y/N/Partial |
|--|-------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | Partial |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role. | Yes |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Yes |
| Staff had any necessary medical indemnity insurance. | Yes |
| <p>Explanation of any answers and additional evidence: At our last inspection in April 2018, non-clinical staff who acted as chaperones had not received a Disclosure and Barring Service (DBS) check and there was no risk assessment in place to demonstrate why such checks were not required. At this inspection we saw that suitable risk assessments were now in place. When possible only clinical staff acted as chaperones.</p> <p>The practice had an up to date recruitment policy and had made significant improvement to the staff files since our last inspection. However, we found a couple of misfiled documents which the practice addressed at the time of our inspection. The practice had employed a dedicated driver but had not completed the required risk assessment. The practice sent us a copy of the completed risk assessment immediately after inspection, however it did not have a review date to ensure that emergent risks were adequately treated.</p> | |

| 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: | Yes June 2018 |
| There was a record of equipment calibration. Date of last calibration: | Yes July 2018 |
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | Yes |
| There was a fire procedure. | Yes |
| There was a record of fire extinguisher checks. Date of last check: | Yes September 2018 |
| There was a log of fire drills. Date of last drill: | Yes November 2018 |
| There was a record of fire alarm checks. Date of last check: | Yes 4 February 2019 |
| There was a record of fire training for staff. | Yes |

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|---|-----------|
| Date of last training: | July 2018 |
| There were fire marshals. | Yes |
| A fire risk assessment had been completed. Date of completion: | June 2018 |
| Actions from fire risk assessment were identified and completed. | N/A |
| <p>Explanation of any answers and additional evidence: Fire drills are carried out at three monthly intervals on all sites.</p> <p>Fire alarm checks were carried out weekly on both sites we have recorded the date for the main site above the Wheaton Aston branch was last tested 5 February 2019.</p> <p>There were two fire marshals for each site.</p> | |

| Health and safety | Y/N/Partial |
|---|----------------------|
| Premises/security risk assessment had been carried out. Date of last assessment: | Yes November 2018 |
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: | Yes June 2018 |
| <p>Explanation of any answers and additional evidence: At our last inspection in April 2018 there had been no health and safety risk assessment for the premises. We saw that this had since been addressed.</p> <p>We also saw that there were suitable certificates in place for fixed wiring and gas safety. The practice also had water risk assessments in place for legionella (legionella is a water borne bacteria which requires a dedicated risk assessment).</p> | |

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

| | Y/N/Partial |
|---|---------------|
| There was an infection risk assessment and policy. | Yes |
| Staff had received effective training on infection prevention and control. | Yes |
| Date of last infection prevention and control audit: | November 2018 |
| The practice had acted on any issues identified in infection prevention and control audits. | Yes |
| The arrangements for managing waste and clinical specimens kept people safe. | Yes |
| Explanation of any answers and additional evidence: The previous infection prevention and control (IPC) lead nurse had retired in November 2018. The new lead had completed a wide variety of interim audits, reviewed IPC risk assessments and generated a comprehensive IPC action plan. We saw that a full IPC audit was planned for June 2019. Of those interim audits completed scores were 99% or 100%. The practice employed contract cleaners and monitored the cleaning schedule. However, as part of our inspection we spot checked the control of substances hazardous to health (COSHH) within the cleaners' cupboard on the main site and found that mops were inappropriately stored wet. The practice took immediate action to correct this and sent us copies of the correspondence between the practice and the cleaning company, which made the requirement for appropriate storage of cleaning materials clear. | |

Risks to patients

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

| | Y/N/Partial |
|---|-------------|
| There was an effective approach to managing staff absences and busy periods. | Yes |
| There was an effective induction system for temporary staff tailored to their role. | Yes |
| Comprehensive risk assessments were carried out for patients. | Yes |
| Risk management plans for patients were developed in line with national guidance. | Yes |
| Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment. | Yes |
| Clinicians knew how to identify and manage patients with severe infections including sepsis. | Yes |
| 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. | Yes |
| There was a process in the practice for urgent clinical review of such patients. | Yes |
| There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency. | Yes |

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|--|-----|
| There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance. | Yes |
| When there were changes to services or staff the practice assessed and monitored the impact on safety. | Yes |

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. | Yes |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Yes |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | Yes |
| Referral letters contained specific information to allow appropriate and timely referrals. | Yes |
| Referrals to specialist services were documented. | Yes |
| There was a system to monitor delays in referrals. | Yes |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Yes |
| 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. | Yes |
| Explanation of any answers and additional evidence: The practice had a proactive referral process with a lead member of staff who checked the system to ensure referrals made had ongoing appointments booked and confirmed. | |

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> | 1.13 | 1.08 | 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> | 10.3% | 9.7% | 8.7% | No statistical variation |

| Medicines management | Y/N/Partial |
|---|-------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Yes |
| Blank prescriptions were kept securely and their use monitored in line with national guidance. | Yes |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Yes |
| 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. | Yes |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. | Yes |
| 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. | Yes |
| 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. | Yes |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Yes |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | Yes |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks | Yes |

| Medicines management | Y/N/Partial |
|---|-------------|
| and disposal of these medicines, which were in line with national guidance. | |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Yes |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Yes |
| 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. | Yes |
| The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases. | Yes |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Yes |
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective. | Yes |
| Medicines for use in an emergency were readily available to staff, and were tamper evident. The practice used a dedicated cold box for transporting vaccines when required. | |

| Dispensary services (where the practice provided a dispensary service) | Y/N/Partial |
|---|-------------|
| There was a GP responsible for providing effective leadership for the dispensary. | Yes |
| The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance. | Yes |
| Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency. | Yes |
| Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions. | Yes |
| Medicines stock was appropriately managed and disposed of, and staff kept appropriate records. | Yes |
| Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective. | Yes |
| If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines. | Yes |
| If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability. | Yes |
| Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence. | Yes |
| Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc. | Yes |
| There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians. | No |
| <p>Explanation of any answers and other comments on dispensary services:</p> <p>At our last inspection April 2018, we found a breach of regulation 17 Good Governance. This was because:</p> <ul style="list-style-type: none"> • Systems to identify, mitigate and manage potential risks to patients and others in relation to the safe management of medicines was not effective. • The security of medicines at both the main and branch surgeries was insufficient as there were no formal checks or records only the verbal assurances assurance of the dispenser competing the task. • the main and branch surgeries only accepted verbal assurance of the dispenser competing the task. • Processes did not ensure that all medicines were stored at the correct temperature at the branch surgery. • Staff at the main surgery did not have written guidance or training on the dispensing of medicines. • The recording of checks on emergency medicines held at the main surgery was not consistent. | |

- Dispensing records had not been kept for the correct period of time.
- There was no record of disposal for returned medicines at the Wheaton Aston branch surgery or record of disposal of some medicines in controlled drug registers.
- Prescription stationary was not managed securely at the Wheaton Aston branch surgery.

At this inspection we found that the practice had addressed these issues. The practice had also employed an appropriately registered dispensary technician who could carry out dispensary checking.

Although all stock was managed appropriately and out of date stock was labelled at the main site, it could have been made clearer to staff that this was not to be used.

The practice was aware that there was not a suitable private room at the Wheaton Aston branch surgery and showed us development plans they had to address this.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong/did not have a system to learn and make improvements when things went wrong.

| Significant events | Y/N/Partial |
|--|-------------|
| The practice monitored and reviewed safety using information from a variety of sources. | Yes |
| Staff knew how to identify and report concerns, safety incidents and near misses. | Yes |
| There was a system for recording and acting on significant events. | Yes |
| Staff understood how to raise concerns and report incidents both internally and externally. | Yes |
| There was evidence of learning and dissemination of information. | Yes |
| Number of events recorded in last 12 months: | 34 |
| Number of events that required action: | 34 |
| Explanation of any answers and additional evidence: There were some inconsistencies in the analysis of events. However, there was evidence that all events were discussed widely with staff at clinical meetings and learning identified and applied where possible. | |

Examples of significant events recorded and actions by the practice.

| Event | Specific action taken |
|--|---|
| A student nurse had administered a combined travel vaccine to a patient, followed by a supplementary typhoid vaccination. This second injection had not been required. | The student and supervising nurse, sought advice from the duty GP. The patient received an apology and reassurance. The nurses used reflective practice to identify how the mistake had happened. They identified several key factors which included distractions by the telephone ringing, room changes and failure to recheck the vaccination after being interrupted. The practice |

| | |
|--|--|
| | supported the nurses with protected time when training students, they also ensured that phone calls were re-routed. The event was shared at a clinical meeting and minutes recorded this. |
| An advanced nurse practitioner had added what they thought was a reminder about a patient's condition to their computer screen. However, the patient call board in reception displayed all the confidential information that had been entered as a reminder. | All staff were reminded to use the electronic tasks system for reminders and reduce the risk of breaching confidential patient information. The patient received an apology and the event was shared with staff at a clinical meeting. Clinical meeting minutes reflected the discussion held. |

| Safety alerts | Y/N/Partial |
|---|-------------|
| There was a system for recording and acting on safety alerts. | Y |
| Staff understood how to deal with alerts. | Y |
| Explanation of any answers and additional evidence: Staff we spoke with knew about recent alerts and could tell us where to find the electronic log. Alerts were received by the management team and shared electronically. There was a record of staff comments and actions taken. | |

Effective

Rating: Good

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

| | Y/N/Partial |
|--|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | Yes |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Yes |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Yes |
| Patients' treatment was regularly reviewed and updated. | Yes |
| There were appropriate referral pathways were in place to make sure that patients' needs were addressed. | Yes |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Yes |
| Explanation of any answers and additional evidence: | |

| 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> | 0.95 | 1.01 | 0.81 | No statistical variation |

Older people

Population group rating: Good

| Findings |
|---|
| <ul style="list-style-type: none"> The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. Health checks were offered to patients over 75 years of age. |

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 medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- 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.

| Diabetes Indicators | Practice | CCG average | England average | England comparison |
|--|---------------|-------------|-----------------|--------------------------|
| The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF) | 73.3% | 78.8% | 78.8% | No statistical variation |
| Exception rate (number of exceptions). | 11.1% (70) | 13.6% | 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) (QOF) | 75.3% | 80.0% | 77.7% | No statistical variation |
| Exception rate (number of exceptions). | 12.4% (78) | 10.6% | 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> | 70.7% | 80.5% | 80.1% | No statistical variation |
| Exception rate (number of exceptions). | 14.8% (93) | 16.5% | 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> | 78.3% | 75.2% | 76.0% | No statistical variation |
| Exception rate (number of exceptions). | 17.6% (126) | 14.1% | 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> | 93.9% | 94.0% | 89.7% | No statistical variation |
| Exception rate (number of exceptions). | 27.9% (51) | 16.8% | 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) (QOF) | 77.5% | 82.3% | 82.6% | No statistical variation |
| Exception rate (number of exceptions). | 2.8% (60) | 5.2% | 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) (QOF) | 92.0% | 89.5% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 3.2% (9) | 4.6% | 6.7% | N/A |

Families, children and young people

Population group rating: Good

Findings

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets.
- 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.
- The practice offered an ante-natal clinic each Wednesday morning. This alternated between Brewood and Wheaton Aston Surgery, when a midwife was in attendance.

| 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) (NHS England) | 69 | 70 | 98.6% | Met 95% WHO based target (significant variation positive) |
| 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) (NHS England) | 87 | 89 | 97.8% | Met 95% WHO based target (significant variation positive) |
| 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) (01/04/2017 to 31/03/2018) (NHS England) | 87 | 89 | 97.8% | Met 95% WHO based target (significant 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) | 84 | 89 | 94.4% | Met 90% minimum (no variation) |

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 74 and over. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- The practice employed a musculoskeletal therapist one day a week who saw patients; advised for straightforward self-help remedies, signposted or referred patients onwards as appropriate.

| 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) | 78.5% | 74.0% | 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) | 67.1% | 74.1% | 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) | 62.2% | 60.8% | 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) | 59.2% | 72.9% | 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) | 58.3% | 58.0% | 51.9% | No statistical variation |

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 of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers 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.

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

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
 - Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. The practice had developed a GP led dementia care programme. This included an assessment, signposting, a dedicated support group and GP led care.
- All staff had received dementia training in the last 12 months.

| Mental Health Indicators | Practice | CCG average | England average | England comparison |
|--|-------------|-------------|-----------------|--------------------------|
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF) | 86.7% | 93.9% | 89.5% | No statistical variation |
| Exception rate (number of exceptions). | 3.2% (1) | 30.0% | 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) | 80.0% | 92.6% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 3.2% (1) | 23.9% | 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) | 69.8% | 78.0% | 83.0% | No statistical variation |
| Exception rate (number of exceptions). | 4.0% (4) | 6.9% | 6.6% | N/A |

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided/There was limited monitoring of the outcomes of care and treatment.

| Indicator | Practice | CCG average | England average |
|---|----------|-------------|-----------------|
| Overall QOF score (out of maximum 559) | 530.7 | 547.5 | 537.5 |
| Overall QOF exception reporting (all domains) | 5.7% | 6.1% | 5.8% |

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

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

- The practice had completed a range of audit and quality improvement measures since our last inspection. For example, they had carried out a cancer audit which determined what improvements could be made to speed up referral. They also carried out a variety of medicine audits to ensure that patients were receiving the most appropriate treatment in line with best practice guidelines.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

| | Y/N/Partial |
|--|-------------|
| Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme. | Yes |
| The learning and development needs of staff were assessed. | Yes |
| The practice had a programme of learning and development. | Yes |
| Staff had protected time for learning and development. | Yes |
| There was an induction programme for new staff. | Yes |
| Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015. | Yes |
| Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation. | Yes |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | Yes |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Yes |
| Explanation of any answers and additional evidence: Staff we spoke with confirmed that they received protected time for learning and that the practice was very supportive of their learning needs. | |

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) | Yes |
| 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. | Yes |
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Yes |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Yes |
| For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services. | Yes |

Explanation of any answers and additional evidence:

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. | Yes |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health. | Yes |
| Staff discussed changes to care or treatment with patients and their carers as necessary. | Yes |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity. | Yes |
| Explanation of any answers and additional evidence: The practice had developed a positive working relationship with the local hospice and liaised with them frequently about end of life care. | |

| 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) <small>(QOF)</small> | 92.8% | 94.6% | 95.1% | No statistical variation |
| Exception rate (number of exceptions). | 0.8% (25) | 0.5% | 0.8% | N/A |

Consent to care and treatment

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

| | Y/N/Partial |
|--|-------------|
| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | Yes |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | Yes |
| The practice monitored the process for seeking consent appropriately. | Yes |
| Explanation of any answers and additional evidence: Staff we spoke with could describe valid consent and how they recorded this. Staff understood Gillick competencies and would support teenage patients appropriately. | |

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. | Yes |
| Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition. | Yes |
| Explanation of any answers and additional evidence: The main site offered baby changing facilities and a room could be made available for breast feeding if required. However, the practice was aware that there was limited provision available at the Wheaton Aston branch surgery. The practice had shared their development plan with us which would improve the Wheaton Aston branch provision. | |

| CQC comments cards | |
|--|----|
| Total comments cards received. | 14 |
| Number of CQC comments received which were positive about the service. | 13 |
| 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 | All 14 of the comment cards received reported that patients were offered a caring service. |
| NHS choices | Most of the 51 comments were positive about good care at the practice. |
| Nursing Home | A representative from the local nursing home told us they were pleased with the care their residents received from the practice. They told us that GP's telephoned the home, the day after a home visit to receive an update on their patients' condition. The GP conducted a dedicated visit to the home every Monday and one of the practice nurses made a dedicated visit every Friday. |

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 |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 10605 | 233 | 111 | 47% | 1.05% |

| 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) | 97.0% | 88.8% | 89.0% | Variation (positive) |
| 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) | 97.0% | 87.6% | 87.4% | Variation (positive) |
| 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) | 100.0% | 95.9% | 95.6% | Significant Variation (positive) |
| 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) | 99.0% | 81.6% | 83.8% | Significant Variation (positive) |

| Question | Y/N |
|---|-----|
| The practice carries out its own patient survey/patient feedback exercises. | Yes |

| Any additional evidence |
|--|
| The practice carried out an annual survey (sometimes twice a year if they were evaluating a new project) to ensure they were able to offer service to meet the needs of their population. The survey was analysed and contained many positive comments about the caring attitude of the entire staff team. |

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. | Yes |
| Staff helped patients and their carers find further information and access community and advocacy services. | Yes |
| Explanation of any answers and additional evidence: Staff had received signposting training to support them with helping patients. The practice had also set up a trial walk in phlebotomy clinic in response to comments made by patients. Although the trial had not been completed and formally evaluated the practice had noted comments made throughout. Some people had found the sit and wait appointment system frustrating whilst others were very positive about the trial. | |

| Source | Feedback |
|-----------------------------------|---|
| Patient Participation Group (PPG) | Members of the PPG we spoke with were positive in their comments about involvement in decisions about care and treatment. |
| CQC comment cards | All the 14 comment cards received were positive about involvement in treatment decisions. |
| Nursing Home | A representative at the local nursing home described the comprehensive and holistic approach the practice took to ensuring that their patients were involved in decisions about their care and treatment. |

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) | 98.0% | 95.5% | 93.5% | No statistical variation |

| | Y/N/Partial |
|---|-------------|
| Interpretation services were available for patients who did not have English as a first language. | Yes |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | Yes |
| Information leaflets were available in other languages and in easy read format. | Yes |
| Information about support groups was available on the practice website. | Yes |
| Explanation of any answers and additional evidence: The electronic sign in screen had a choice of nine languages, including English. | |

| Carers | Narrative |
|--|--|
| Percentage and number of carers identified. | The practice had identified 179 patients as registered carers this was 1.6% of the practice patient list. The practice had also identified that they had 74 patients who received support from a carer. |
| How the practice supported carers. | The practice had a carers champion who could sign post and support carers. There were leaflets about local support activities for carers within the waiting areas. The practice had dedicated support for carers of people with dementia and a dedicated dementia champion. The practice was a dementia friend and group support was available through planned events. The practice also offered an influenza vaccination to all carers. |
| How the practice supported recently bereaved patients. | The practice staff signposted recently bereaved patients to appropriate support. Patients were offered flexible appointments if required. |

Privacy and dignity

The practice respected.

| | Y/N/Partial |
|--|-------------|
| Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. | Yes |

| | |
|--|-----|
| Consultation and treatment room doors were closed during consultations. | Yes |
| A private room was available if patients were distressed or wanted to discuss sensitive issues. | Yes |
| There were arrangements to ensure confidentiality at the reception desk. | Yes |
| Explanation of any answers and additional evidence: Staff spoke quietly at reception and there was also music available to promote auditory privacy when required. | |

Responsive

Rating: Good

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. | Yes |
| The facilities and premises were appropriate for the services being delivered. | Yes |
| The practice made reasonable adjustments when patients found it hard to access services. | Yes |
| 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. | Yes |
| Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services. | Yes |
| Explanation of any answers and additional evidence: The main site was purpose built with level access and a lift when access to the first floor was required. The practice was aware that the Wheaton Aston branch required some improvement and showed us their development plans to improve the reception and waiting areas. This would also provide a private room should patients wish to use one. | |

| Practice Opening Times | |
|-------------------------|--|
| Day | Time |
| Opening times: | |
| Monday | 8am – 6.30pm |
| Tuesday | 8am – 6.30pm |
| Wednesday | 8am – 6.30pm |
| Thursday | 8am – 6.30pm |
| Friday | 8am – 6.30pm |
| Saturday | 8am – 12 noon |
| Appointments available: | |
| Monday | Clinical appointments 8am – 12 noon and 3pm-6.10pm |
| Tuesday | Clinical appointments 8am – 12 noon and 3pm-6.10pm |
| Wednesday | Clinical appointments 8am – 12 noon and 3pm-6.10pm |
| Thursday | Clinical appointments 8am – 12 noon and 3pm-6.10pm |
| Friday | Clinical appointments 8am – 12 noon and 3pm-6.10pm |
| | |

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 10605 | 233 | 111 | 47 % | 1.05% |

| 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) | 99.2% | 94.6% | 94.8% | Variation (positive) |

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.
- There was a medicines delivery service for housebound patients.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- 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.
- Parents with concerns regarding children under the age of 10 could attend a drop-in clinic held at the same time as the twice weekly baby clinic.

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.
- The practice was open until 6.30pm each evening Monday to Friday.
- Pre-bookable appointments were also available to all patients at additional locations within the area. The practice was a member of a GP locality group covering Stafford Rugeley and the Seisdon area of Staffordshire. Appointments were available 6.30pm – 8pm weekdays and Saturday 9am until 1pm and Sundays and bank holidays 10am until 12 noon.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- 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
(including people with dementia)**

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice had established a GP led dementia service, which included a dementia champion.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

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. | Yes |
| The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention. | Yes |
| Appointments, care and treatment were only cancelled or delayed when absolutely necessary. | Yes |
| Explanation of any answers and additional evidence: Patients requiring a home visit were encouraged to telephone the practice before 10.30 am wherever possible. The practice understood that people could feel unwell late in the day. Requests for home visits were triaged by a member of the clinical team and the practice used a template to determine the clinical need. | |

| 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) | 90.0% | N/A | 70.3% | No statistical variation |
| 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) | 80.7% | 61.6% | 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) | 85.9% | 59.9% | 65.9% | Variation (positive) |
| 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) | 84.3% | 70.9% | 74.4% | No statistical variation |

| Source | Feedback |
|-------------|---|
| NHS website | Most of the 51 comments were positive about access, however an occasional comment reflected some difficulty in obtaining a routine appointment. |
| CQC | Thirteen of the 14 comment cards were positive about the ease of making a |

| | |
|---------------|--|
| comment cards | routine appointment. One comment card referred to an occasional difficulty experienced with making an appointment. |
|---------------|--|

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care/ Complaints were not used to improve the quality of care.

| Complaints | |
|--|---|
| Number of complaints received in the last year. | 5 |
| Number of complaints we examined. | 5 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 5 |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | 0 |

| | Y/N/Partial |
|--|-------------|
| Information about how to complain was readily available. | Partial |
| There was evidence that complaints were used to drive continuous improvement. | Yes |
| <p>Explanation of any answers and additional evidence: *The complaints leaflets were in a drawer behind the reception desk at the main site. We raised this with the practice who immediately rectified this and made the leaflets available with the other leaflets within the waiting area. However, the complaints leaflets were readily available in the waiting are at Wheaton Aston branch surgery.</p> <p>The practice had received very specific complaints which had been thoroughly investigated and linked to significant events where appropriate.</p> | |

Example(s) of learning from complaints.

| Complaint | Specific action taken |
|---|---|
| A patient had been left a voicemail asking them to contact the practice to discuss a recent blood test result. Unfortunately, the person leaving the message had forgotten the practice would be closed that afternoon for protected learning time. | Discussed at a team meeting held and staff reminded to check when leaving such messages that the practice would be open when they are requesting patients to call back. |
| A patient complained about feeling rushed during their consultation, and had more than one issue to be discussed. | The patient was encouraged to make double appointment for future complex needs appointment. |

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.

| | Y/N/Partial |
|---|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Yes |
| They had identified the actions necessary to address these challenges. | Yes |
| Staff reported that leaders were visible and approachable. | Yes |
| There was a leadership development programme, including a succession plan. | Yes |
| Explanation of any answers and additional evidence: The practice shared their succession plans and demonstrated their commitment to a new multi-disciplinary team clinical model; which would be flexible and responsive to the needs of the practice population. | |

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. | Yes |
| There was a realistic strategy to achieve their priorities. | Yes |
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Yes |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Yes |
| Progress against delivery of the strategy was monitored. | Yes |
| Explanation of any answers and additional evidence: The practice had developed a vision and strategy to take them into the future and were committed to the ongoing developments their strategy required. | |

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. | Yes |
| Staff reported that they felt able to raise concerns without fear of retribution. | Yes |
| There was a strong emphasis on the safety and well-being of staff. | Yes |
| There were systems to ensure compliance with the requirements of the duty of candour. | Yes |
| The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy. | Yes |
| Explanation of any answers and additional evidence: All staff we spoke with confirmed that they felt supported in raising any concerns and would be listened to by leaders. Staff told us of a positive team approach and that they felt valued and respected by the practice leaders and the management team. | |

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

| | Y/N/Partial |
|--|-------------|
| There were governance structures and systems which were regularly reviewed. | Yes |
| Staff were clear about their roles and responsibilities. | Yes |
| There were appropriate governance arrangements with third parties. | Yes |
| Explanation of any answers and additional evidence: The practice was committed to a whole team approach and were completing plans to rotate all staff through the main site and both branches to ensure consistency of approach. | |

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. | Yes |
| There were processes to manage performance. | Yes |
| There was a systematic programme of clinical and internal audit. | Yes |
| There were effective arrangements for identifying, managing and mitigating risks. | Yes |
| A major incident plan was in place. | Yes |
| Staff were trained in preparation for major incidents. | Yes |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Yes |

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. | Yes |
| Performance information was used to hold staff and management to account. | Yes |
| Our inspection indicated that information was accurate, valid, reliable and timely. | Yes |
| There were effective arrangements for identifying, managing and mitigating risks. | Yes |
| Staff whose responsibilities included making statutory notifications understood what this entails. | Yes |
| Explanation of any answers and additional evidence: The practice had taken the opportunity to review many of its practices following our April 2018 inspection. At this inspection they demonstrated how they had used the learning from previous CQC inspections to inform their plans. | |

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. | Yes |
| Staff views were reflected in the planning and delivery of services. | Yes |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Yes |
| Explanation of any answers and additional evidence: The practice had commenced a trial walk in phlebotomy clinic in response to needs expressed by its population. | |

Feedback from Patient Participation Group.

| Feedback |
|---|
| The patient participation group (PPG) were positive about the open and responsive nature of the practice. They told us that the practice always listened to suggestions and considered issues the PPG raised. The PPG had been consulted about the temporary reduction in service at the Coven branch surgery and had agreed to the days the reduced service was to be offered. |

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

| | Y/N/Partial |
|---|-------------|
| There was a strong focus on continuous learning and improvement. | Yes |
| Learning was shared effectively and used to make improvements. | Yes |
| The practice had detailed policies to support both complaints and significant events. They took the time to review complaints and review as significant events appropriately. All complaints and events were widely shared and discussed at clinical meetings to ensure staff could learn and improve. | |
| The service had developed and implemented a GP led dementia plan. This included assessments and an annual reassessment for those at risk. Support and a treatment plan for patients who received a dementia diagnosis were detailed. The treatment plan included monitoring the effectiveness of any medication as early in the plan as practicable. A dedicated dementia champion was part of the in-house support team. The dementia champion could provide both direct support and signposted patients and their families to other agencies when required. The practice had become a dementia friend and offered information about group support and events for those with or caring for people with dementia. | |
| The practice worked in collaboration with other practices within their locality in Staffordshire. The practice supported staff's professional development. We saw evidence of staff being supported in their career progression. | |

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.