

# Care Quality Commission

## Inspection Evidence Table

### Trent Meadows Medical Practice (1-560531666)

Inspection date: 15 October 2019

Date of data download: 11 October 2019

## Overall rating: Good

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

## Safe

## Rating: Good

### Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
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: We met with the former safeguarding lead GP who had recently retired but provided support to the practice during the inspection. <ul style="list-style-type: none"><li>The practice had a new safeguarding lead GP in place</li></ul>	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> <li>• Had developed the safeguarding policy in line with current updates</li> <li>• Staff had received safeguarding training which included recent updates in respect of female genital mutilation and exploitation in line with best practice updates.</li> <li>• The former safeguarding lead was trained to Level 4 and had completed PREVENT training and proposals were in place for the new lead to complete this training. Prevent training for healthcare staff is to enable staff to identify early signs of an individual being drawn into for example radicalisation.</li> <li>• All safeguarding patients are electronically read coded and included links to household members. The practice monitored their safeguard register but did not separate the adult and child register which they assured us they would now utilise the separate electronic codes.</li> <li>• An audit was regularly completed as a form of housekeeping to ensure that for example those children who were fostered then adopted that their records were amended accordingly, and codes removed.</li> <li>• The practice reported that they had difficulty with Health Visitor attendance, but invites are forwarded to attend meetings. School nurses were invited to meetings but to date had not attended.</li> <li>• The practice used a pro forma to inform safeguarding conferences which included the required details.</li> <li>• We found that safeguarding was a regular agenda item in the practice meetings.</li> <li>• Children non-attendance at A&amp;E, for secondary care appointments or childhood immunisations were monitored, reviewed and where appropriate recalled.</li> <li>• The former safeguarding lead was a member of the safeguarding steering group.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance 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

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: At both sites 02.02.2019	Yes
There was a record of equipment calibration. Date of last calibration: At both sites 03/10/2019	Yes
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: at Branston on 16.10.2019 and Stretton on 05.06.2019	Yes
There was a log of fire drills. Date of last drill: At Stretton on 10.10.2019 and Branston on 13.02.2019	Yes
There was a record of fire alarm checks. Date of last check: Weekly at each site	Yes
There was a record of fire training for staff. Date of last training: As per the staff training matrix on an individual basis	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: At Branson on 15.08.2019 at Stretton on 03.01.2019	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: The practices had completed a Legionella risk assessment at the Branston site on 12.03.2019 and Stretton on 16.02.2019.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: At the Branston site on 15.08.2019 and Stretton site on 03.01.2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: At Branston site on 12.12.2018 and at Stretton site on 12.12.2018	Yes

## 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
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 17/07/2019	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes

## 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
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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
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 and 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
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	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

## 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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.79	0.93	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2018 to 30/06/2019) (NHSBSA)	6.9%	8.4%	8.6%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	4.92	5.51	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	1.28	1.97	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	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	Yes

Medicines management	Y/N/Partial
including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	
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 and disposal of these medicines, which were in line with national guidance.	NA
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
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
<p>Explanation of any answers and additional evidence:</p> <p>Emergency medicines, oxygen and a defibrillator were at both the main Branson and Stretton site. The provider had risk assessments in place in respect of emergency medicines not held by the practice. The provider completed additional risk assessments for analgesia and a medicine used for example in childhood croup during the inspection.</p> <p>High risk medicines from 1 April 2018 were taken back into secondary care at the practice request including Amber Two medicines as the practice saw potential gaps could occur in monitoring and therefore patient safety risk. A medicine used to reduce the risk of blood clots was also monitored and prescribed in secondary care.</p> <ul style="list-style-type: none"> <li>• The practice completed audits and monitored patients new to the practice quarterly to ensure that these patients are also placed into the secondary care monitoring</li> <li>• Secondary care medicines prescribed in hospital were added onto the patient's electronic record to mitigate risk of potential interactions with other medicines.</li> <li>• The practice offered patients the electronic prescribing service (EPS).</li> </ul>	

## 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.	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: March 2019 to October 2019	12
Number of events that required action:	12
Explanation of any answers and additional evidence: The practice had a policy in place for reporting incidents and events which staff we spoke with understood and could readily access.	

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

Event	Specific action taken
Patient referral required for physiotherapy however there had been an internal communication omission.	This was reported actioned and investigated by the practice. The practice put measures and actions in place to mitigate the risk of reoccurrence. This included discussion at the GP practice partner meeting as should the patient not have contacted the practice and chased the referral this would not have been picked up.
Patient misheard the name call to the GP consulting room attended the room and the GP did not check it was the correct patient.	This was reported actioned and investigated by the practice. The practice put measures and actions in place to mitigate the risk of reoccurrence.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: The practice had a system for recording and acting on alerts however we noted gaps in February 2019 whereby some alerts appear not to have been received. The practice investigated this during the course of the inspection and mitigation to reduce the risk of reoccurrence. The provider assured us that they would review published alerts against the spreadsheet they held to ensure compliance with recommended professional actions. Immediately following the inspection, the provider reviewed all alerts and those not received were audited by clinical staff and patients who may be affected by the medicine's alerts recalled for clinical review, supported by the practice management team. We were assured that all appropriate measures had been 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
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	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 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
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes

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) (01/07/2018 to 30/06/2019) <small>(NHSBSA)</small>	0.32	0.57	0.75	Variation (positive)

## 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. For example, the practice had identified 100 patients assessed as severe frailty.</li> <li>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.</li> <li>The practice carried out structured annual medication reviews for older patients.</li> <li>Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.</li> </ul>



- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Provide GP services to their patients living in care homes supporting them in addition with a weekly GP visit and providing the care home with a direct line to the office manager at the practice.

## People with long-term conditions

## Population group rating: Good

### Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Provided a collaborative clinic with their clinical pharmacist in a 'one stop' appointment for medicines and care plan reviews.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Patients who attended for regular blood tests for monitoring of their medicine to reduce the risk of blood clots were provided with a regular morning appointment. The anti-coagulation clinics however managed these patients. The staff utilised the NICE decision aid to support patient transition to other medicines to reduce the risk of blood clots where clinically appropriate.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered blood pressure monitoring devices.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs and patients could be referred to the pulmonary rehabilitation service.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	83.2%	78.4%	78.8%	No statistical variation
Exception rate (number of exceptions).	16.8% (106)	13.1%	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	81.7%	76.7%	77.7%	No statistical variation

months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>				
Exception rate (number of exceptions).	4.6% (29)	7.6%	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>	87.6%	81.3%	80.1%	Tending towards variation (positive)
Exception rate (number of exceptions).	7.0% (44)	11.2%	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>	76.8%	75.6%	76.0%	No statistical variation
Exception rate (number of exceptions).	1.3% (12)	5.6%	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>	92.8%	90.6%	89.7%	No statistical variation
Exception rate (number of exceptions).	5.0% (11)	9.6%	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>	84.5%	83.6%	82.6%	No statistical variation
Exception rate (number of exceptions).	2.2% (40)	3.6%	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>	93.0%	91.0%	90.0%	No statistical variation
Exception rate (number of exceptions).	4.4% (8)	6.2%	6.7%	N/A

**Findings**

- The practice has met the minimum 90% target for all four childhood immunisation uptake indicators. The practice has met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for one of the four childhood immunisation uptake indicators. (please add additional comment for any childhood immunisations indicators below 90%).
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children’s appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.
- The main Branston site was co-located with the Sexual Health clinic.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	100	102	98.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	113	120	94.2%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	113	120	94.2%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	113	120	94.2%	Met 90% minimum

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

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

Population group rating: **Good**

### Findings

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

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) <small>(Public Health England)</small>	77.6%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) <small>(PHE)</small>	75.6%	61.2%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2017 to 31/03/2018) <small>(PHE)</small>	59.6%	57.1%	57.3%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) <small>(PHE)</small>	65.3%	74.8%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) <small>(PHE)</small>	62.1%	53.8%	51.9%	No statistical variation

### Any additional evidence or comments

The practice waiting rooms highlighted cancer awareness and screening at both main and branch sites. Staff were encouraging patients opportunistically to take up the offer of screening, as well as providing health promotion support and literature.

**People whose circumstances make them vulnerable**

**Population group rating: Good**

**Findings**

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- We saw examples of the practice considering vulnerable groups such as the practice clinical meeting in September 2019 which had noted the need to achieve consensus on palliative care planning templates and out of hours communication.
- From December 2019 the practice were to provide enhanced cancer care reviews in association with Macmillan following staff training which was due to take place in December.
- Practice provided two carer champions and had a supporting carers action plan in place as well as two clinical and two non-clinical cancer care champions.

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

**Population group rating: Good**

**Findings**

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required. The opportunity to attend at quieter times and a quiet area to wait were provided at both sites
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training and plans were in place to become a dementia friendly practice, there was a dementia champion GP lead at the practice. There were easy read laminated signs for example for the toilets as dementia friendly signage throughout the practice.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	91.5%	92.1%	89.5%	No statistical variation
Exception rate (number of exceptions).	19.0% (11)	16.5%	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)	91.5%	91.1%	90.0%	No statistical variation
Exception rate (number of exceptions).	19.0% (11)	16.4%	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)	75.0%	82.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.9% (2)	3.4%	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.**

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	558.5	547.3	537.5
Overall QOF score (as a percentage of maximum)	99.9%	97.9%	96.2%
Overall QOF exception reporting (all domains)	4.2%	5.8%	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
Quality improvement activity was targeted at the areas where there were concerns.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

The practice completed both clinical and non-clinical audits which were discussed at partnership, clinical and business meetings at the practice. These included for example:

- Minor surgery
- Cytology
- Long term condition monitoring searches
- Peer to Peer audits
- Epilepsy medicines and family planning
- Medicine audits following patient safety alerts
- A&E attendances
- Patient satisfaction surveys
- Staff surveys
- Medication review surveys
- Workflow audits

The practice provided additional practice Advanced Nurse Practitioner pilot support for the winter pressures including a minor illness clinic and triage support as a hub site for inner Burton On Trent. The practice found that they had seen 300 patients over the last two years for minor injury when patients may otherwise have attended A&E.

### 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	Yes



their performance was poor or variable.	
Explanation of any answers and additional evidence:	
<p>The practice management had reviewed the work force and skill mix and recruited a clinical pharmacist to the practice and taken on an additional nurse. The reception team had received signpost training with further innovations planned for reception staff training once agreed. The practice manager was a director with the Primary Care Network (PCN), including innovations such as social prescribing. The healthcare assistant has extended roles for example monitoring in pre-diabetes patients following a training module. A practice nurse had completed accredited training for the initiation of a medicine used in diabetes and another nurse planned training for spirometry tests in lung disease.</p> <p>The system in place to supervise and review competence when staff had enhanced roles was with GP review and supervision. At the time of the inspection the lead nurse was in the process of deciding which would be the most appropriate documented competency framework for their needs. In a move for the practice to formalise their inclusion of staff in formal reviews of their advanced roles with supervision and audit of their clinical decision making.</p> <p>The practice team included a nurse prescriber and a clinical pharmacist. They advised the GPs provided support with case by case discussions, that national and Clinical Commissioning Group (CCG) formulary's and antibiotic prescribing guidance was followed. The clinical pharmacist was training with Centre for Pharmacy Postgraduate Education (CPPE) which offers continuous professional education opportunities for the NHS pharmacy workforce in England in general practice pathways and was supported in their MSc in advanced clinical practice.</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)	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

## 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	Yes

developing a long-term condition and carers.	
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	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

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>	97.3%	95.1%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.2% (7)	0.8%	0.8%	N/A

### Consent to care and treatment

#### The practice 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
Policies for any online services offered were in line with national guidance.	Yes
Explanation of any answers and additional evidence: Staff we spoke with demonstrated their understanding of consent and described how this was documented with the patient's electronic records. Staff completed training in Mental Capacity Act and consent. The practice training programme included mandatory training arranged with differing pre-set training topics on a quarterly rolling rota in which quarter four included mental capacity and consent. Reminders were emailed to staff to encourage them to complete their training. We discussed best interest decision making and the consideration of early care planning documentation regarding advance decision making.	

## Well-led

Rating: Good

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	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 were aware of changes locally and advised on the challenges it faced of increasing demand with a background of new house building locally above 3500 new properties, and the reduction of two GPs within the practice team.  The practice in discussion with NHS England reviewed the practice list against their catchment boundary/area and discovered that over 1700 patients received a service who were outside of the practice catchment area. The practice was in the process of writing to these individual patients. The practice focus was on patient safety and to ensure it could meet the needs of patients within the contracted patient catchment area.  There were clear succession plans in place regarding practice management and it was clear that the GPs had been in discussion about recruitment and retention of new GPs to enable future succession planning. The practice advised that they had submitted applications for overseas recruitment of GPs and were awaiting responses from the Home Office.  We saw that the practice had revised their succession plan and had adjusted their skill mix to meet the challenges they had at the time of inspection.	

### 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:

Staff had awareness of the practice vision although this was not verbatim staff understood each had roles and responsibility in achieving the practice strategy. The vision being to provide the highest standards of healthcare to their patients within the resources available to them. To monitor, audit and review the services they provide and strive for continuous improvement and responsiveness. To ensure that staff are highly trained and work in a stimulating and rewarding environment. To embrace new opportunities in a changing NHS.

## 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
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes

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

Source	Feedback
Staff	Staff we spoke with told us that they felt listened to and supported by the practice leadership team. Staff told us that they could raise issues with the leadership team safely.

## 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 identified key lead roles within the practice. Staff were clear about these changes and knew who to go to for advice and support.

### 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
Explanation of any answers and additional evidence:	
Staff we met were able to describe what they would do for example in the event of a telephone or IT system failure and who they would refer to in this event. Management described who held copies of the business continuity/major incident plan off site. Not all staff could fully recall the details of the incident plan training, but staff had received in house support and training in preparation for major incidents.	

### 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 was proactive in streamlining the systems they had in place for efficient access and ability to monitor and review performance. For example, the practice had developed:	

- A repository spreadsheet accessible to all staff for policies and protocols which were updated. Should there be an electronic outage and the system goes down there was a safety net of this being available on a password protected memory stick for staff to access information
- Training access broken into three monthly segments on a rolling rota
- The practice had implemented a new health and safety system which was managed by an external contractor which enabled clear monitoring systems.

## 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
The practice had an active Patient Participation Group.	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
<p>Explanation of any answers and additional evidence:</p> <p>At the time of the inspection the practice had need to reduce the opening hours at the branch site Stretton. Patients could be seen at the Branston main site every afternoon but at the Stretton branch site this had been reduced to two afternoons per week in the short term. This had been discussed and described to the Patient Participation Group and notices of these changes had been posted at the Stretton branch site.</p> <p>The practice had completed a staff survey in August 2019 with a 79.3% response rate. The analysis included monitoring the results by staff team role, such as reception, administration and secretarial, nurses and managers. The analysis of this survey also took account of the qualitative feedback documented on the survey responses. Findings included whether staff felt respected, communication, supported, encouraged in using initiative and ability to obtain advice as well as whether staff would recommend the practice as a great place to work. Following the analysis of the survey an action plan was derived with plans to implement changes and a repeat of the survey.</p>	

## Feedback from Patient Participation Group.

Feedback
<p>We spoke with the PPG chair and members of the PPG during the course of the inspection. The PPG met approximately 10 times a year and met with the practice management, three or four times a year.</p> <p>Information on how to join the PPG were posted in the waiting rooms and on the waiting room television display screen. Information from the PPG was available on the notice boards and within a folder within the waiting room.</p> <p>The PPG were aware of and consulted with the practice on the challenges regarding GP recruitment and providing a GP service at its main and branch sites. The practice availability was for a GP service every week day morning at the Stretton and Branston site but had need to reduce their GP availability for three afternoons at the Stretton site in the short term. Information about this was posted at the Stretton site and on the practice website. The PPG were aware that patients had feedback that they had heard that the practice at Stretton was to close which was not the case.</p>

The patients had made the PPG aware that there were transport cost implications for some patients who perhaps could ill afford costs and that there was no direct bus route between the sites.

The PPG assisted the practice in its in-house patient survey and the analysis of the results and resultant action planning. The PPG for example were involved in supporting the practice during the flu vaccination season with additional health promotion opportunities for example this year included advice on prostate cancer, diabetes and cancer screening.

Two members of the PPG remarked that they did not feel the practice listened to the issues they discussed, and others were positive that the issues discussed at meetings were listened to and when appropriate actioned.

### **Any additional evidence**

We spoke with five patients who were at the practice on the day of inspection. Patients advised they could obtain an urgent same day appointment. Patient appointments would be offered at either the main or branch site. However, some patients at the branch Stretton site noted that this impacted on them in respect of ease of transport, time and fiscally if the appointment offered was at the main Branston site. Patients described difficulty at times in seeing their preferred GP within two weeks. Patients were offered on line access to appointments up to two weeks in advance.

Patients outside of the catchment area were being contacted to inform them of the contracted practice boundary. One patient remarked that this felt to them that those currently registered were being removed in order to accommodate new patients from new local housing developments which was to their detriment. We fed back information from those patients we met to the practice, who were clear that this would be discussed at their regular practice meeting but described their awareness of the potential impact of this short-term measure and that they would minimise disruption where safely able to do so.

Patients we spoke with told us that they found the care and treatment by clinical staff at the practice as good or very good and highly valued the service they received at the Stretton branch site.

It was clear from patients we spoke with that patients who predominately attended the branch site had concerns that the service may eventually close. We fed this back to the practice who advised that the measures put in place were short term, patient safety focused with measures in place to actively recruit additional GPs and there was no plan to close the branch site.

Thirty-two CQC comment cards were completed by patients at the practice, all provided positive comments and seven contained mixed comments regarding access, two commented on the attitude of reception staff and one on the display screen updates within the waiting room.

We saw that patients had feedback by use of the Friends and Family Test survey. For example, in August 2019, 80, patient experience forms/texts were received. Out of the 80, 41 patients were extremely likely to recommend the practice, 21 were likely to recommend, 12 neither, two unlikely and four extremely unlikely. The practice produced action plans in relation to the feedback received including the areas they did well as well as areas to improve.



## 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`
Explanation of any answers and additional evidence: The practice was a training practice and had been in receipt of positive feedback from both the deanery and from trainee GPs.  The practice were active in their involvement with the local Primary Care Network (PCN) of which the practice manager proposed to work solely for one day per week.  The practice actively engaged with the change transformation team to assist the team with business planning and workflow optimisation. The practice had engaged with the Productive General Practice Programme and this had enabled focus on areas of change that had positively impacted and benefited patients and staff. For example, the programme they engaged with had time saving benefits for 72 appointments for long term condition patients per month, 52 hours per month for administration and administration, GP appointments up to 28 hours per month as efficiencies.  The practice was an apprenticeship provider for NVQ 2/3 Business Administration and Customer Services, which had led to date on each apprentice being successful in finding employment within the 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 Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

## Glossary of terms used in the data.

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