

Care Quality Commission

Inspection Evidence Table

Bridge Surgery (1-558852239)

Inspection date: 29 October 2019

Date of data download: 28 October 2019

Overall rating: add overall rating here

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

Safe Rating: Requires Improvement

The practice was rated requires improvement in providing a safe service because:

- There were gaps found in the recruitment records for some staff and in records of staff vaccination and immunity histories.

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.	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

Safeguarding	Y/N/Partial
Explanation of any answers and additional evidence:	
<p>The practice had contracted cleaning staff and the service had not supplied the practice with evidence of their DBS checks, references or training for their role. The practice acted immediately and requested copies of these documents from the company during the inspection.</p> <p>The practice regularly invited the Health Visitors to attend their safeguarding meetings and reported that they had access to the health visiting team via a Hub contact number.</p> <ul style="list-style-type: none"> • The practice held safeguarding meetings quarterly and discussed concerns as required during the weekly GP meeting. • The Safeguarding Lead monitored patients who did not attend for practice appointments with the GP, nurse and secondary care appointments. All letters for children under five were sent to the GP after being work flowed by the scanning administrators. A dedicated administrator dealt with all safeguarding correspondence. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	No
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Explanation of any answers and additional evidence:	
<p>We reviewed seven recruitment files. Within the files we reviewed we found an absence of photographic identity, gaps in referencing and in obtaining staff vaccination and immunity histories. New staff had been seen by occupational health and were provided with fit for employment records specific for their role. Staff for a service the practice contracted had not supplied the practice with evidence of the DBS checks, references or training for their role.</p> <p>The practice had a DBS Check Policy and Risk Assessment (September 2014), which considered the various staff roles at the practice with regard to whether a DBS check was required. Discussion around retrospective DBS checks took place during the partnership meeting held in June 2019, and it was agreed that these would be carried out.</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: 24/09/2019	Yes
There was a record of equipment calibration. Date of last calibration: 12/07/2019	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: 07/02/2019	Yes
There was a log of fire drills. Date of last drill: 11/09/2019	Yes
There was a record of fire alarm checks. Date of last check: 18/07/2019-serviced	Yes
There was a record of fire training for staff. Date of last training: various dates in staff training	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 27/03/2013	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: All staff had been in receipt of fire marshal training.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 29/03/2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 14/02/2019	Yes
Explanation of any answers and additional evidence: The landlord of the premises had completed formal risk assessments without a copy provided to the practice. A health and safety and fire risk assessment had also been completed by an external company and an action plan developed to address any identified risks. The practice had completed a physical security risk assessment as part of their data security toolkit submission. An external company completed risk assessments from which the completion of a Legionella risk assessment had been an action point. This assessment had been completed and a copy held by the practice.	

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: July 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
Explanation of any answers and additional evidence: The practice had external audits completed and had found improvements in the percentage scored within the audit year on year. This year they had achieved 94% in their infection prevention and control audit. A legionella risk assessment had been completed and action plans derived from this audit to reduce risk were in progress.	

Risks to patients

There were adequate in 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 clinical 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
Explanation of any answers and additional evidence: There was clear supportive information in place for locum GPs who may attend the practice.	

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)	1.02	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)	10.9%	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)	4.97	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)	2.23	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.	Partial

Medicines management	Y/N/Partial
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
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> <ul style="list-style-type: none"> • Blank prescriptions were kept securely, and their use monitored in line with national guidance. However, we found that the keys for these were held on a hook in a room accessible to all staff including contracted staff. • The clinical pharmacist took up the role to reconcile patients discharge medicines into the practice electronic systems. The practice had robust monitoring of shared care drugs completed by the practice pharmacist and overseen by a GP. The practice pharmacist maintained a list of Amber 2 medicines, checked recalls, invited patients for tests, and once the monitoring was completed reset the recall dates. • The clinical pharmacist attended clinical supervision meetings and had access to a pharmacist mentor and educational supervisor. • The practice continued to monitor patients on medicines used to reduce the risk of blood clots using INR Star software with GP supervision. • The Controlled Drug standard operating procedure was reviewed considering recent guidance issued by the Controlled Drugs Accountable Officer by the practice pharmacist. Letters were sent out to patients to inform them Pregabalin and Gabapentin would be reclassified as 	

Medicines management	Y/N/Partial
<p>Controlled Drugs on 01/04/19.</p> <ul style="list-style-type: none"> • The annual risk assessment for the practice held emergency drugs was completed by the healthcare assistant and practice pharmacist on 29/04/19. • The practice pharmacist reviewed the Quarterly Prescribing Pack provided by the CCG and relevant points were raised at the practice's clinical governance meeting. 	

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 in last 12 months:	19
Number of events that required action:	11
<p>Explanation of any answers and additional evidence:</p> <p>Significant event reports were all reviewed at the clinical governance meetings held quarterly and at other team meetings as required for example at nurse or GP weekly meetings.</p> <p>The practice completed an annual review of significant events to identify any trends. The last one of events that took place in 2018 were reviewed in their meeting on 11/02/19, where they had found an increase in incidents at other organisations being reported eight out of 18 compared to four out of 18 in 2017.</p> <ul style="list-style-type: none"> • The practice used an electronic system (Datix) to report significant events and soft intelligence to the CCG which started in June 2019. • The practice shared anonymised selected significant event reports with the PPG. • Feedback from significant event discussions were relayed back to patients where appropriate for example, following a complaint. 	

Example of significant events recorded and actions by the practice.

Event	Specific action taken
Patient whose health deteriorated whilst at the practice	The practice completed a debrief and review of the incident and this was shared with all staff. There was a positive patient outcome and staff had responded well to the incident.

Safety alerts	Y/N/Partial
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There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: We saw examples of actions taken on recent alerts for example, regarding sodium valproate.	

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>	0.68	0.57	0.75	No statistical variation

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

- The practice provided support to their patients in care homes including a regular ward round visit, the patient numbers had increased from 79 to 106 since the last inspection.
- The practice had implemented AliveCor screening for patients including older people to assist with screening for atrial fibrillation.

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. The practice had increased the hours provided by practice nurses to improve access to long term condition appointments under the extended access initiative.
- There was a pre-diabetes service in place for patients.
- 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. The practice had implemented AliveCor screening for patients to assist with screening for atrial fibrillation.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	88.2%	78.9%	79.3%	Tending towards variation (positive)
Exception rate (number of exceptions).	19.7% (140)	13.6%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	84.8%	77.0%	78.1%	No statistical variation
Exception rate (number of exceptions).	9.0% (64)	8.2%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	82.7%	81.9%	81.3%	No statistical variation
Exception rate (number of exceptions).	12.0% (85)	11.0%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	73.9%	75.6%	75.9%	No statistical variation
Exception rate (number of exceptions).	0.9% (7)	6.2%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	93.8%	90.6%	89.6%	No statistical variation
Exception rate (number of exceptions).	11.0% (20)	8.6%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	88.9%	84.7%	83.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	1.9% (31)	3.8%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) <small>(QOF)</small>	96.4%	92.5%	91.1%	Tending towards variation (positive)
Exception rate (number of exceptions).	3.5% (7)	4.8%	5.9%	N/A

Findings

- The practice met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all four childhood immunisation uptake indicators. The practice had implemented the use of tabards for nurses during the immunisation clinics to reduce the impact on children of staff uniforms and to ensure nursing staff were not interrupted during these clinics unless urgently required.
- 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.

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)	84	86	97.7%	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)	77	80	96.3%	Met 95% WHO based target
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)	77	80	96.3%	Met 95% WHO based target
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)	77	80	96.3%	Met 95% WHO based target

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. 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.
- Extended access to GP services were available between 6.30pm and 8pm
- The practice provided telephone appointments

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)	75.6%	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) (PHE)	76.0%	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) (PHE)	60.0%	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) (PHE)	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) (PHE)	57.1%	53.8%	51.9%	No statistical variation

Any additional evidence or comments

The practice advised that the cervical cancer screening figures had improved, and they had signed up to the local enhanced scheme for cancer care. The practice had a recall system in place and non-

attendees were contacted and followed up.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required by staff offering flexibility regarding appointment modes and times.
- All patients with a learning disability were offered an annual health check and those unable to attend the practice were supported further by completing these checks at the patients' home.
- The practice participated and had fully engaged with the Learning Disabilities Mortality Review (LeDeR) programme. This was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice provided easy read material for learning disability patients.
- The practice registered and provided support to homeless patients
- The practice provided a Jayex board which displayed the patient's names and room number visually.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

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

- Patients with poor mental health, including dementia, were referred to appropriate services.
- Receptionists had been in receipt of dementia friendly training.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	93.6%	94.1%	89.4%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	12.2%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	93.6%	92.3%	90.2%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	11.7%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	84.2%	85.3%	83.6%	No statistical variation
Exception rate (number of exceptions).	7.3% (8)	5.1%	6.7%	N/A

Any additional evidence or comments

The practice low exception reported which meant that more patients were in receipt of the care and treatment they required.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	559	No Data	539.2
Overall QOF score (as a percentage of maximum)	100%	No Data	96.4%
Overall QOF exception reporting (all domains)	5.6%	No Data	No Data

	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:

<p>The practice completed audits in line with CCG requests, such as antibiotic and hypnotic prescribing as well as their clinical audits. These included for example;</p> <ul style="list-style-type: none"> • A Chronic Obstructive Pulmonary Disease (COPD) toolkit audit. COPD is an umbrella term used to describe progressive lung diseases. • End of life care audit • The practice had overhauled and reviewed their effective shared care arrangements (ESCAs) for Amber two medicines. These are medicines requiring initiation by a specialist, but with the potential to transfer to primary care, within written and agreed shared care frameworks.
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Any additional evidence or comments

Three GPs, a practice nurse and practice pharmacist were registered as Antibiotic Guardians. One GP a practice nurse and practice pharmacist completed an antimicrobial prescribing and stewardship competencies framework. A GP had completed the RCGP Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) antibiotic toolkit. The practice was the winner of the CCG's antibiotic campaign waiting room competition in December 2017.

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.	Partial
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	NA
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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>We were informed that new staff completed on line mandatory training as well as face to face training in house and at external training events. Staff received support by shadowing staff in their role and with a three-month probationary period appraisal.</p> <p>Staff training was supported by the practice, for example a senior nurse was undertaking the Holistic Nurse Assessment and Physical Examination Level six course at Keele University and prospective training in a nurse prescribing course.</p> <p>There was an absence of a documented new staff induction process with the exception of locum GPs. There were no documented competencies including staff signing to say they had been in receipt of information such as policies during an induction or that they met the standards expected by the practice and signed off as competent. It was clear in the practice minutes of a meeting that had taken place in September 2019 that this had been discussed, and the practice would be considering ways in which this may be implemented in the near future.</p> <p>The clinical pharmacist was supported in their role. This included attendance at clinical and practice meetings and access to training at the practice. The Clinical Pharmacist attended the Clinical Pharmacist in General Practice Education (CPPE) GP Practice Pathway which provided training for pharmacists for GP practice roles. There was no formalised competency framework in place for staff with extended roles.</p> <p>The practice in their presentation had recognised that appraisals of non-clinical staff had not been completed on an annual basis. Dates for staff's individual appraisals had been diarised to take place in January 2020 with staff having the opportunity to self-appraise and consider any personal development goals.</p> <p>As a member of the nursing team had recently left, the remaining practice nursing team had increased their hours to cover this provision for their patients without need of locum nurse support. Nurse appraisals took place with a GP and were in the process of being planned.</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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	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	Yes

processes to make referrals to other services.	
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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
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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	94.4%	95.7%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.4% (12)	0.8%	0.8%	N/A

Consent to care and treatment

The practice obtained to demonstrate that it 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
Policies for any online services offered were in line with national guidance.	Yes
The practice provided a range of consent forms including those for contraceptive devices, minor surgical procedures and immunisations.	

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 leadership understood the challenges to quality and sustainability and identified the actions necessary to address these challenges for example: <ul style="list-style-type: none">• Changes were introduced to their duty doctor systems which were revised in September 2019 to ensure equity of workload each week day morning.• The practice was an active participant in the extended access service on a rota basis with the 18 other practices in their Primary Care Network (PCN).• Staff had completed the workflow optimisation training to enable streamline and workflow efficiencies.• The practice had participated in the Productive General Practice programme with NHS England. This provides an easy-to-use, practical, and flexibly designed programme to enable all staff to take a fresh look at the changing needs of patients and develop services that will improve safety and reliability, patient and carer experience, staff experience and productivity. The practice had identified areas for practice improvement, and had action plans for implementation these included: <ul style="list-style-type: none">• Reviewing the National GP patient survey• Safe prescribing• Team stability• Appraisals for non-clinical staff• Updates to staff contracts and handbook• Review of roles and responsibilities• The plans for an electronic system for sharing pathology results between secondary and primary care• A nurse practitioner role• Challenges included the size and restrictions of the practice premises. The practice and work with the PCN included local improvement plans such as: <ul style="list-style-type: none">• The appointment of a social prescriber• First contact physiotherapist service• Increasing clinical pharmacy time• Working at scale with other providers.	

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
<p>Explanation of any answers and additional evidence:</p> <p>The practice described the changes they had implemented since the last inspection which included changes made to the premises. These included for example:</p> <ul style="list-style-type: none"> • Sale and leaseback of the building • Refurbishment of the treatment room • Improvements in Infection Control Audit 	

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	<p>Staff spoke highly of the practice leadership and described the ease at which they could seek support, openly discuss suggestions and felt valued as individuals and as a team. Staff described a flat structure where their views were treated equally by all staff regardless of their role.</p> <p>The practice held twice yearly social activities usually around Christmas and one other. Staff told us they were involved and engaged with the Productive General Practice initiatives.</p>
Staff survey of their roles and responsibilities within the practice.	<p>Staff had completed an exercise whereby they posted notes on category boards, such as clinical, administrative, other, their daily roles and responsibilities and tasks.</p> <p>Once mapped these could be reviewed to ascertain if only one person for example completes an integral role and therefore the deputising safety was absent. The practice could then put in place measures to mitigate any identified risk.</p> <p>Staff had fully engaged with this process and had found it a useful and energising exercise.</p>

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
<p>Explanation of any answers and additional evidence:</p> <p>Since the last inspection there had been some changes to management team with the introduction of the assistant practice manager appointment, an increase in nurse administration time and sourcing specialist human resources advice.</p> <p>The practice had an organisation structure with staff with lead roles and responsibilities. The practice was in the process of mapping staffs daily work and responsibilities and were involved in leadership programmes to review resilience and capacity. The lead GP and Practice Manager had completed a leadership and management course run by Keele University.</p> <p>The lead GP was undertaking the Rosalind Franklin NHSLA programme aimed to support participants to be innovators, leaders, and team-members. The ambition being to have improved leadership a greater positive impact on organisational culture, and inclusive, person-centred care; to work more strategically with greater collaboration across large and complex programmes, departments, services and systems of care, leading to less waste and more efficient use of resources.</p> <p>The practice had reviewed systems and processes and as a consequence strengthened arrangements around shared care medicines, safeguarding arrangements, procedures regarding pathology results workload and monitoring.</p>	

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.	Partial
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:	
<p>There were comprehensive assurance systems which were regularly reviewed and improved for example:</p> <ul style="list-style-type: none"> • The practice had overhauled and reviewed their effective shared care arrangements (ESCAs) for Amber two medicines. These are medicines requiring initiation by a specialist, but with the potential to transfer to primary care, within written and agreed shared care frameworks. • Warfarin monitoring had been reviewed and measures put in place to ensure sight of monitoring results prior to repeat prescribing, including interim arrangements with the secondary care team support with the provision of a spreadsheet with patients monitoring blood results. • Practice had an external infection prevention and control audit which from 2014 had increased from a score of 76% to 94% in 2019. • Locum and trainee induction packs had been implemented • The practice had developed a Carers Champion role who met with the local facilitator from Carers Association South Staffordshire (CASS) and receptionist training was provided in July 2018 by the Carers Association and who also attended the PPG meeting. <p>We found was that the practice did not hold a copy of the environmental risk assessment completed by the landlord. This was however requested during the inspection. However, the practice had completed a health and safety and fire risk assessment as well as a physical security risk assessment.</p>	

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.	No
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence: The practice recruitments records for some staff were incomplete and the practice had no copy of the risk assessments completed in respect of the premises from the landlord to ensure that any derived action plans had been fully implemented.	

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
Explanation of any answers and additional evidence: The practice had acted monitored and acted on feedback it received. Examples included: <ul style="list-style-type: none">• The practice telephone system had been upgraded, following feedback, for example from the National GP Patient survey.• Changes were made to the duty doctor system to try to increase the opportunity for patients to see or speak to their usual GP following feedback from the National GP Patient survey.• The practice consulted with their PPG membership and virtual PPG. The GP and practice manager attended bimonthly PPG meetings. There was in fact a waiting list for people wanting to join the face to face group which was only restricted due to environmental reasons due to the room and seating area availability.• Staff meeting attendance, interaction engagement and feedback.• Three GPs had chosen to reduce their hours from nine to eight sessions from January 2018 to improve their work life balance. One of the GPs retired in July 2018 and the practice had found difficulty in recruiting a replacement. During this time, they used carefully selected regular locum GPs (often previous GP trainees) to maintain the same levels of GP service and ensure continuity. The practice had received positive patient feedback about the locum GPs as demonstrated in their Friends and Family Test feedback forms in May 2018. At the time of the	

inspection the practice had successfully recruited a new Salaried GP and former practice GP trainee in August 2019.

- The practice continued to work with other local practices sharing policies and procedures.
- A practice representative attended the monthly CCG Steering Group meetings. The agenda and minutes were reviewed prior to each weekly GP meeting.
- The practice attended multidisciplinary team meetings (MDT) including quarterly meetings with St Giles Hospice, Community matron and District Nursing Team to discuss palliative care patients.
- The practice is a member of the East Staffordshire Partnership PCN responsible for delivering the extended access rota from Sept 2018 along with the other 17 practices in the CCG.
- The practice held twice yearly social activities for the staff usually around Christmas and one other.
- Staff told us they were involved and engaged with the Productive General Practice initiatives.

Feedback from Patient Participation Group.

Feedback

The PPG reported positively on the practice engagement and relationship with them. The PPG met regularly and the face to face meetings were held at the practice where a member of the practice management team and a GP attended as well as 10 PPG group members. There was a waiting list to join the PPG face to face meetings due to the constraints of the meeting room size. The PPG had tried options such as the waiting room to accommodate a larger group, but this had been assessed as acoustically challenging. The practice also had a virtual PPG group of approximately 40 members.

The PPG advised they felt listened to, their views actioned and acted upon and fully engaged with and valued by the practice.

Indicative's the PPG had regularly engaged with included for example:

- Upright seating for patients in the reception waiting room.
- Flu vaccination clinic attendances
- Waiting room child's play train was donated
- Improving health promotion awareness, such as cancer screening uptake.

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:	
<ul style="list-style-type: none"> • The lead GP was undertaking the Rosalind Franklin NHSLA programme aimed to support participants to be innovators, leaders, and team-members • The practice participated and had fully engaged with the Learning Disabilities Mortality Review 	

(LeDeR) programme. This was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.

- The practice had taken part in the NHSE England Productive General Practice programme
- Staff had been trained in workflow optimisation and active signposting
- Clinical Pharmacist had joined the practice team
- The practice had taken part in a multi-diagnostic centre pilot with the Queens Hospital
- Split pre-registration pharmacist programme (Pharmacy and GP Practice) in conjunction with local pharmacy which was due to commence summer 2020.
- Technology enabled care including diagnostic tools for the detection of atrial fibrillation.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

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

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

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

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

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

Glossary of terms used in the data.

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