

Care Quality Commission

Inspection Evidence Table

Tunstall Primary Care (1-582449503)

Inspection date: 19 May 2021

Date of data download: 15 April 2021

Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe

Rating: Good

At our previous inspection 31 Jul 2019, we rated the practice as requires improvement overall and in the Safe and Well Led domain areas. A Requirement Notice was served in Regulation 11, Consent and Regulation 17, Good Governance. During the inspection on 19 May we found the provider had made improvements in all the identified areas in particular:

- Patient consent was audited and valproate pregnancy prevention plans in place for women of childbearing age which included an assessment of capacity to decision make.
- The provider had ensured they had identified all the children with a child protection plan in place registered, these were coded and validated with the local safeguarding teams and health visitors.
- Non-clinical staff had completed safeguarding training at a level appropriate to their role.

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 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

Safeguarding	Y/N/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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had appropriate safeguard policies in place that were regularly reviewed, for example the last review of their Safeguarding Adults at Risk of Harm policy was in March 2021 and included information on adults who lack mental capacity to make a specific decision. Information contained within in the policy included for example, 'Contest' which is the Government's Counter Terrorism Strategy and 'Prevent' which focuses on preventing people becoming involved in terrorism, supporting extreme violence or becoming susceptible to radicalisation. The practice held a separate Female Genital Mutilation (FGM) policy which had been reviewed in April 2021. The practice policy noted when a child was at immediate risk of FGM or had experienced FGM and included guidance for a compulsory referral to be made to social services or the police. However, the policy did not highlight the use appropriate electronic read codes to document FGM which the practice was considering.</p> <p>The safeguarding children policy was last reviewed in February 2021 which was updated to include use of Arden's template for the electronic system coding. The practice held a separate policy for modern slavery and human trafficking last reviewed in April 2021.</p> <p>The practice had read and considered the information in the thematic review of Infants under 1 Year written by the Designated Nurse for Safeguarding Children from the Staffordshire Clinical Commissioning Groups and Chair of the SSSCB Child Safeguarding Practice Review subgroup.</p> <p>The practice chaperone policy was last reviewed I January 2021 and clearly noted that chaperones were required to be trained for the role. It did not state that they had to be subject to a satisfactory DBS check and the practice confirmed they would amend this.</p>	

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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a recruitment policy in place last updated in October 2020. We reviewed two recruitment records. The practice completed DBS checks on all staff and at an enhanced level for clinical roles. There was a process for checking the qualifications for clinical staff, but a process had not been implemented for checking relevant qualifications for non-clinical staff. The practice planned to redress this.</p>	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person.	Yes

Date of last inspection/test: May 2021	
There was a record of equipment calibration. Date of last calibration: 15/10/2020	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
A fire risk assessment had been completed. Date of completion: 02/11/2020 and next review was due before: 22/10/2021 Branch site: 16/04/2020 and next review was due before 16/04/2022	Yes
Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence: The practice held a Control of Substances Hazardous to Health (COSHH) Policy which was accessible to all staff which was last updated In April 2021. The practice had identified a member of staff tasked with ensuring these risk assessments were up to date and for arranging the provision of information, instruction, training and retaining records. Staff were subject to an unannounced fire drill and this last took place on 16/04/2021 at the Packmoor site and 22/01/2021 at the Tunstall site neither contained a list of the staff present for this drill but could be checked from the staff duty rotas. The fire risk assessment had been completed but a few actions had yet to be concluded according to the records reviewed. The practice manager had emailed the relevant contractor to request clarity on the outstanding actions and risk mitigations and awaited their documented response. The practice Gas Safety Certificate was in place, dated 17/09/2020.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: Various dates	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Various dates	Yes
Explanation of any answers and additional evidence: Both practice premise locations were leased, and the property management estates provided the practice with access to the premises/security risk assessments carried out.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met/not 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: 08/12/2020	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 an infection prevention and control policy in place, last updated in May 2021 which included the suspected notifiable diseases list for staff to refer too and for example their Clinical Waste Management Protocol.	

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
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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
Explanation of any answers and additional evidence: The practice management team ensured that the administration and reception teams rotas were in place four weeks in advance. These were generally set rotas as most staff maintained their same hours and covered both practice sites. There were contingencies in place in the event of staff absence as many staff work part time hours and agreed to complete additional hours to support the practice or covered each other with arranged shift swaps. We saw that for example on a Monday demonstrated as one of the busiest phone call days, four GPs were available as well as the on-call duty GP. The practice ensured both male and female GPs were available to support patients' gender preferences. The skill mix of staff included Advanced Nurse Practitioners and the Advanced Paramedic who were available for assessment of patients with acute needs. We saw that the practice had responded to call volume increases and added 10 phone lines. The practice was in process of interviewing for the addition of three new reception/admin staff to further support the increased call volumes. They had changed their phone call number in the queue message, from 10 to 20 as patients had reported to them that they had been cut off when call waiting. The practice recognised that the number of lines for staff to call out needed to be increased and they had increased these by 10 number of lines The practice was in the process of further developing their new staff induction processes to be competency based.	

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
Referrals to specialist services were documented, contained the required information 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

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) (01/01/2020 to 31/12/2020) <small>(NHS Business Service Authority - NHSBSA)</small>	0.79	0.81	0.76	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). (01/01/2020 to 31/12/2020) <small>(NHSBSA)</small>	4.4%	7.7%	9.5%	Variation (positive)
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 (01/07/2020 to 31/12/2020) <small>(NHSBSA)</small>	4.39	5.22	5.33	Tending towards variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2020 to 31/12/2020) <small>(NHSBSA)</small>	115.6‰	182.9‰	127.0‰	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) <small>(NHSBSA)</small>	0.24	0.70	0.67	Variation (positive)

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks 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

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:	17
Number of events that required action:	17
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a significant event policy in place that was accessible to all staff, last updated in February 2021. The practice reported patient safety incidents using a template on their Team Net electronic systems and also the National Reporting and Learning System (NRLS). This is a central database of patient safety incident reports.</p> <p>The practice maintained a significant event spreadsheet which enabled governance and trend oversight on the incidents and events.</p>	

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

Event	Specific action taken
Swab specimens were placed into vaccine fridge.	<p>The practice investigated the incident and identified causative factors.</p> <p>The Specimens were removed from the vaccine fridge and forwarded to the pathology laboratories.</p> <p>The vaccine fridge was deep cleaned.</p> <p>All staff were notified not to put any specimens or other objects into the vaccine fridge. A laminated sheet was placed on the fridge stating the above.</p> <p>The practice made changes to prevent the event happening again and installed a dedicated specimen samples fridge at the Tunstall Primary Care site and a small desktop fridge at the Packmoor site.</p>
Allergic reaction to a childhood immunisation	<p>The practice investigated the incident and identified causative factors.</p> <p>The staff responded to the emergency and the GP and nurse fully implemented the allergic reaction protocols promptly.</p> <p>The patient received emergency care and support at the practice and attended a local hospital via ambulance.</p> <p>Clinical records were updated to note the patient had an allergic response to the vaccine. The patient was treated with suitable medicines and cared for at the practice until transferred to the local hospital. The practice completed the pharmacy yellow safety card reporting of vaccination reactions record.</p>

	Following the incident changes were made to always ensure that these immunisation clinics were only ever scheduled before 5pm when a GP is always on site in case of a similar event.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes

Effective

Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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

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 medicines 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.

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.
- 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.
- 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.

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. (01/04/2019 to 31/03/2020) <small>(QOF)</small>	85.2%	78.4%	76.6%	Tending towards variation (positive)
PCA* rate (number of PCAs).	15.8% (123)	8.1%	12.3%	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 (01/04/2019 to 31/03/2020) <small>(QOF)</small>	96.2%	88.4%	89.4%	Tending towards variation (positive)
PCA rate (number of PCAs).	17.3% (44)	8.6%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	76.1%	82.3%	82.0%	No statistical variation
PCA rate (number of PCAs).	2.7% (7)	3.9%	5.2%	N/A

The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	55.1%	64.0%	66.9%	Tending towards variation (negative)
PCA rate (number of PCAs).	11.6% (64)	11.3%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	60.3%	71.9%	72.4%	Tending towards variation (negative)
PCA rate (number of PCAs).	3.5% (48)	4.9%	7.1%	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 (01/04/2019 to 31/03/2020) <small>(QOF)</small>	95.1%	92.7%	91.8%	No statistical variation
PCA rate (number of PCAs).	6.9% (12)	3.9%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	67.4%	72.5%	75.9%	No statistical variation
PCA rate (number of PCAs).	10.5% (58)	8.8%	10.4%	N/A

Any additional evidence or comments

We reviewed the systems in place regarding long term condition management. We found that clinical searches were completed, and patient invites for reviews as well as recalls.

Records reviewed demonstrated that those who attended for reviews the consultation notes were updated appropriately. The practice was aware, and patient recalls in place for the four patients that had a blood test result (HbA1c) that could indicate prediabetes.

Families, children and young people

Population group rating: **Good**

Findings

- The practice met the minimum 90% for four of five childhood immunisation uptake indicators. The practice was slightly under the WHO based national target of 95% (the recommended standard for achieving herd immunity) for three of the five childhood immunisation uptake indicators. The childhood immunisations for children aged 5 who had received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) was slightly below the 90% target.
- 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) (01/04/2019 to 31/03/2020) (NHS England)	151	165	91.5%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	188	198	94.9%	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) (01/04/2019 to 31/03/2020) (NHS England)	187	198	94.4%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	187	198	94.4%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	167	190	87.9%	Below 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>

Any additional evidence or comments

The practice nurses reviewed non-attenders for childhood immunisations and considered strategies to encourage take up. This included, text message reminders, telephone calls and letters. In the event that children did not attend or take up the offers following these reminders the practice team alerted Health Visitors.

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 medicines without the need to attend the surgery.

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). (Snapshot date: 30/09/2020) (Public Health England)	67.3%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	73.1%	71.9%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2019 to 31/03/2020) (PHE)	59.9%	N/A	63.8%	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 (01/04/2019 to 31/03/2020) (QoF)	36.7%	86.6%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	52.5%	55.6%	54.2%	No statistical variation

Any additional evidence or comments

The practice nursing team encouraged cervical screening uptake, they used text message, phone calls and letter reminders to follow up on non-attenders. The nursing team analysed the information regarding non-attenders to ascertain whether there was any trend they could identify in a particular geographic area, population group or ethnicity in order to target information regarding the importance of screening and improve uptake.

Unverified data from the practice systems demonstrated that women aged between, 25-49 years, who had attended cervical screening within the target period 2020/2021 was 68% and for women aged 50-64 years the unverified data showed uptake as 73%.

Unverified data from the practice systems demonstrated that women, 50-70 years, screened for Breast Cancer in last 36 months was at 77%, which had shown increased uptake from 73.1%.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- 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.
- The practice reviewed young patients at local residential homes.

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 medicines.
- 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.
- All staff had completed suicide awareness training.
- 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.

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 (01/04/2019 to 31/03/2020) <small>(QOF)</small>	65.5%	84.6%	85.4%	Tending towards variation (negative)
PCA rate (number of PCAs).	4.5% (4)	10.2%	16.6%	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 (01/04/2019 to 31/03/2020) <small>(QOF)</small>	80.0%	81.1%	81.4%	No statistical variation
PCA rate (number of PCAs).	8.0% (10)	6.0%	8.0%	N/A

Any additional evidence or comments

The practice had lower exception reporting for patients with severe mental health and informed us they actively encouraged attendance for care plan reviews.

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)	490.83	Not Available	533.9
Overall QOF score (as a percentage of maximum)	87.8%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	6.9%	Not Available	5.9%

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

Any additional evidence or comments
The practice had completed a retrospective death audit. Following the audit learning was shared effectively and used to make improvements. Examples included: staff completion of additional training in suicide awareness.

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.	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
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence:	

Coordinating care and treatment

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

Indicator	Y/N/Partial
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

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 and tackling obesity.	Yes

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
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence: The practice had a policy in place in respect of DNACPR and Recommended Summary Plan for Emergency Care and Treatment which was readily accessible to all staff (ReSPECT).	

Well-led

Rating: Good

At our previous inspection 31 Jul 2019 we rated the practice as requires improvement overall and in Well Led. A Requirement Notice was served in Regulation 17, Good Governance.

During the inspection on 19 May 2021 we found the provider had made improvements in the identified areas within the well led domain namely:

- Internal governance arrangements had improved.
- Appropriate escalation processes to raise and share risk with the Clinical Commissioning Group had been established.

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

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: The practice had developed a mission statement. This included for example; a culture of listening and caring for patients and staff, employing and training local staff, transparency of practice and reflection and learning. The practice strategy at the time of the inspection was not yet completed.	

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
<p>Explanation of any answers and additional evidence:</p> <p>The practice whistleblowing policy was last reviewed In April 2021. The practice had a lone worker policy in place which was accessible to staff and was last updated in April 2021, this included a staff checklist for staff who completed home visits. The practice had a low staff turnover and low sickness absence levels. Staff we spoke with told us that they were proud to work as part of the team at Tunstall Primary Care and they had job satisfaction.</p>	

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

Source	Feedback
Staff	Staff felt part of a team and their ideas and suggestions were freely discussed at their various meetings.

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

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 quality improvement programme in place.	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

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes

Performance information was used to hold staff and management to account.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

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 (PPG).	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>The practice had completed an in-house survey and reviewed the patient survey results from 2019 to 2020. They had consulted with their PPG who had suggested some minor changes to the questions and agreed that by keeping the survey small, it would encourage more patients to participate. They received 62 completed questionnaires out of a total distribution of 100. This had also attracted 10 patients who said they would be interested in joining the PPG. The survey showed that patient satisfaction overall was 85.47% that is patients who described the service as good/very good or excellent.</p>	

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
<p>Explanation of any answers and additional evidence:</p> <p>A number of audits completed by the clinical staff demonstrated their focus on continuous learning and improvement and the recommendations from the audits were shared. For example, a retrospective death audits found that young or middle-aged males with mood problems, previous history of drug overdose or attempted suicide/self-harm, relationship breakdown or financial issues seemed to be high risk for suicide. Learning was shared effectively and used to make improvements for example staff completed additional training in suicide awareness and clinicians completed detailed mental health risk assessments including the steps taken to mitigate any identified risks.</p> <p>The practice found they could improve upon areas such as making early contact with bereaved families. Staff suggestions to improve included, telephone contact as well as sending a condolence card. The staff considered the potential for an anonymous feedback form regarding the support received to the bereaved family.</p>	

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.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)).
- ‰ = per thousand.