Care Quality Commission

Inspection Evidence Table

St George Health Centre (1-541937793)

Inspection date: 05 March 2019

Date of data download: 04 March 2019

Overall rating: Good

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

Safe Rating: Requires Improvement

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Policies were accessible to all staff.	Yes
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
There were systems to identify vulnerable patients on record.	Yes
There was a risk register of specific patients.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social	Yes

Safeguarding	Y/N/Partial
workers to support and protect adults and children at risk of significant harm.	
Explanation of any answers and additional evidence: The practice was aware of recent changes made to the recognised safeguarding guidance regarding the level of training different staff should complete. We saw evidence they had taken steps to ensure their staff training met these new guidelines. On the day of our inspection we found the information about chaperones was not easily visible for patients. We discussed this with the practice who took immediate steps to put chaperone posters in each clinical room and sent us evidence to confirm this the next day.	

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 and if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Staff had any necessary medical indemnity insurance.	Yes

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: 19/12/2018	Yes
There was a record of equipment calibration. Date of last calibration: 6/11/2018	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.	Yes
There was a log of fire drills. Date of last drill: 15/2/19	Yes
There was a record of fire alarm checks.	Yes
There was a record of fire training for staff. Date of last training: 15/2/19	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 20/01/2019	Yes
Actions from fire risk assessment were identified and completed.	Yes

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 26/2/2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Yes
Explanation of any answers and additional evidence: At our last inspection of St George Health Centre in May 2014, we said the practice should have an overall health and safety risk assessment for the building. On this inspection we saw evidence the practice had such an assessment in place.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Date of last infection prevention and control audit:	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Partial (see below)
There were two sharp boxes for the disposal of needles and syringes that had not been appropriately labelled.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Yes

Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Yes
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented.	Yes
There was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHS Business Service Authority - NHSBSA)	1.16	0.84	0.94	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) (NHSBSA)	7.9%	9.6%	8.7%	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 (01/04/2018 to 30/09/2018) (NHSBSA)	4.63	5.22	5.64	Variation (positive)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2018 to 30/09/2018) (NHSBSA)	3.67	2.21	2.22	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about	Yes

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
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
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.	No
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial (see below)
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Partial (see below)

Explanation of any answers and additional evidence:

When we checked the practice stock of emergency medicines we found some were out of date. The next day the practice sent us a copy of their significant event form they had completed to ensure they learnt from the incident. This showed they had taken immediate action and had replaced the expired medicines.

The practice had a defibrillator on site and systems to ensure these were regularly checked and fit for use. However, on the day of our inspection there was no paediatric pad and no evidence such as a risk assessment to show the practice had decided one was not required.

We found a box of medicines stored in a fridge was wet. It is believed this was due to the box being put up against the wall of the fridge.

We saw evidence that the practice was undertaking a comprehensive review of their emergency drugs to bring the operating practices on both sites into alignment.

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 (since April 2018):	19
Number of events that required action:	11

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

Event	Specific action taken
A nurse working at the practice realised they had not renewed their nurse registration when due and informed the practice.	The practice immediately cancelled all surgeries the nurse was due to take and the nurse reported herself to the Nursing and Midwifery Council. The subsequent investigation showed the nurse had run one two-hour clinic while not appropriately registered. Since last registering, they had changed email address and had not received the usual reminders. The practice discussed the issue with other clinicians to ensure the learning was shared.

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
Explanation of any answers and additional evidence: During our inspection we looked at how the practice had responded to a recent alert regarding sodium valproate and found the practice had records which showed they had taken all the appropriate action. (Sodium valproate is a medicine used to treat epilepsy and bipolar disorder.)	

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.

Please note the QOF figures in part of this evidence table are based on the data available from 2017/2018 prior to St Georges Health Centre and Lodgeside Surgery had become one entity. Additional information can be seen within the tables to show unverified amalgamated data that has been gathered by the provider since this has occurred.

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

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHSBSA)	0.67	0.77	0.81	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.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The practice participates in a befriending scheme for the elderly in partnership with a local charity.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. The practice had a GP with a special interest in endocrinology (Endocrinology is the branch of medicine concerned with endocrine glands and hormones.)
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- The practice supplied additional information following the inspection to the current published Quality and Outcome Framework (QOF) data for 2017/2018. The published data had shown, higher than average exception reporting rate for some of the long-term condition indicators. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.) The additional information evidenced that steps had been taken to significantly improve the figures for exception reporting.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	94.2%	79.7%	78.8%	Significant Variation (positive)
Exception rate (number of exceptions).	36.5% (188)	20.6%	13.2%	N/A
Amalgamated unverified data - Exception reporting for Fireclay Health 2017/2018	30%			N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	85.3%	78.7%	77.7%	No statistical variation
Exception rate (number of exceptions).	15.5% (80)	14.4%	9.8%	N/A
Amalgamated unverified data - Exception reporting for Fireclay Health 2017/2018	14%			N/A

The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	87.0%	83.6%	80.1%	No statistical variation
Exception rate (number of exceptions).	25.2% (130)	16.5%	13.5%	N/A
Amalgamated unverified data - Exception reporting for Fireclay Health 2017/2018	17%			N/A
Additional information: The practice supplied following the inspection additional information regarding the exception reporting. The amalgamated information showed considerable improvements to the previous figures and the practice has supplied information to show the additional steps they are taking to ensure an improved monitoring system will be in place to reduce the number of patients identified within this category.				

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	79.4%	74.9%	76.0%	No statistical variation
Exception rate (number of exceptions).	19.7% (130)	12.2%	7.7%	N/A
Amalgamated unverified data - Exception reporting for Fireclay Health 2017/2018	11%			N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	90.6%	91.2%	89.7%	No statistical variation
Exception rate (number of exceptions).	21.6% (41)	14.4%	11.5%	N/A
Amalgamated unverified data - Exception reporting for Fireclay Health 2017/2018	16%			N/A
Additional information: The practice supplied following the inspection additional information regarding the exception reporting. The amalgamated information showed considerable improvements to the previous figures and the practice has supplied information to show the additional steps they are taking to ensure an improved monitoring system will be in place to reduce the number of patients identified within this category.				

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	89.2%	82.1%	82.6%	No statistical variation

150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	8.0% (95)	6.0%	4.2%	N/A
Amalgamated unverified data - Exception reporting for Fireclay Health 2017/2018	6%			N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	83.3%	89.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	5.5% (7)	6.2%	6.7%	N/A
Amalgamated unverified data - Exception reporting for Fireclay Health 2017/2018	4%			N/A

Families, children and young people — Population group rating: Good

Findings

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- One of the GPs is a breast-feeding mentor and patients wishing to discuss breast feeding were encouraged to book with this GP
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Young people could access services for sexual health and contraception.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) ((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	156	164	95.1%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who	138	150	92.0%	Met 90% minimum

have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)				(no variation)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	137	150	91.3%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	136	150	90.7%	Met 90% minimum (no variation)

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- The practice performance in providing cervical screening was below the national target of 80% and their rate of ensuring patients with newly diagnosed cancer were treated within the set time scale was lower than the national average.

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)	70.4%	73.6%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	70.1%	70.6%	70.0%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	52.7%	56.5%	54.5%	N/A

The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	57.1%	71.4%	70.2%	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)	33.8%	53.4%	51.9%	No statistical variation

Any additional evidence or comments

The practice data for the uptake of cervical screening was in line with local and national averages, but below the 80% coverage target for the national screening programme. We discussed this with the practice who told us they were working to improve the uptake rate. We saw evidence that:

- In the past 12 months the practice had reviewed how they ensured cervical screening was taken up by eligible patients.
- They ensured women could be offered appointments at different times throughout the week, including evening and Saturday morning and a female sample-taker was available.
- The practice had a system of re-call and reminders including telephone calls and letters to prompt eligible patients to attend. The practice provided additional information to show that they had been able to attain higher participation in the cervical smear testing programme than the surrounding practices for patients with a learning disability. The practice IT system could remind clinicians that a patient was due a cervical screening so they could discuss this with the patient if they attended for another reason.
- All sample-takers had received appropriate training.
- All sample-takers monitored results from the samples they take including their inadequate rate.

The practice showed us unverified data from April 2018 to February 2019 which showed their current rate of cervical screening had risen to 79% and they had increased their rate of cancer diagnosis in the past year.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- 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 held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances. They supported patients living in a local substance misuse service.
- The practice supported patients with learning difficulties living in two local care homes for people with complex needs.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- The practice supplied additional information following the inspection to the current published Quality and Outcome Framework (QOF) data for 2017/2018. The published data had shown, higher than average exception reporting rate for some of the mental health indicators. The additional information evidenced that steps had been taken to improve the figures for exception reporting.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	95.5%	93.0%	89.5%	No statistical variation
Exception rate (number of exceptions).	62.7% (37)	20.7%	12.7%	N/A
Amalgamated unverified data - Exception reporting for Fireclay Health 2017/2018	12%			N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	96.3%	91.5%	90.0%	No statistical variation
Exception rate (number of exceptions).	54.2% (32)	17.4%	10.5%	N/A
Amalgamated unverified data - Exception reporting for Fireclay Health 2017/2018	9.3%			N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	72.4%	82.8%	83.0%	No statistical variation
Exception rate (number of exceptions).	35.6% (16)	6.6%	6.6%	N/A
Amalgamated unverified data - Exception reporting for Fireclay Health 2017/2018	8%			N/A

Any additional evidence or comments
The practice supplied following the inspection additional information regarding the exception reporting. The amalgamated information showed considerable improvements to the previous figures and the practice has supplied information to show the additional steps they are taking to ensure an improved monitoring system will be in place to reduce the number of patients identified within this category.

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	559.0	544.8	537.5
Overall QOF exception reporting (all domains)	12.1%	7.3%	5.8%

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

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

- We saw evidence the practice had completed a full cycle audit on gestational diabetes. (Full cycle audits are those that have been repeated to monitor improvements made.)

- We saw evidence the practice had complete a full cycle audit on emergency contraception, which was undertaken to ensure the practice was meeting new guidelines which had been published.

Any additional evidence or comments

The practice exception rates for a number of measures in the Quality Improvement Framework (QOF was significantly higher than the local and national averages for the year 2017/2018. They provided additional information (which remains unverified) after the inspection demonstrating the achievements for 2018/2019. These showed considerable improvements against all aspects of the Clinical Commission Group data.

Effective staffing

The practice was unable 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.	Partial (see below)
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial (see below)
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:

The practice had a list of training it considered to be essential for staff in their various roles. We saw that this did not include the Mental Capacity Act, or competence to give consent as mandatory training for non-clinical staff or Health Care Assistants (HCAs). However, we saw evidence that three of the four HCAs had completed this training. The day after our inspection the practice told us all the outstanding training had been scheduled for the remaining staff and would be completed within one week.

There were some processes or structures for providing clinical support and supervision to nurses and HCAs. This was through having clinical leads (GP) at each location, nurse meetings and a provision of information. There was no lead nurse and nurses and HCAs were line managed by a practice manager for the other aspects of their employment. The practice manager coordinated meetings and two GPs chaired the meetings and were leads in the decision making. There were no records of individual clinical supervision available. The day after our inspection the practice sent us information about how they planned to provide clinical support and supervision to nurses and HCAs, although there were unable to show where this would be effective, and it was not yet embedded in the practice.

The practice was taking part in a pilot scheme to improve patients transition to and from secondary mental health services. In addition to the pilot, an HCA who had received appropriate training to support patients and signpost them to other relevant services. However, there was no evidence that patients were being assessed as being within the HCAs area of competence prior to being seen, or that the care and support given as evidenced in the patient's clinical notes, had been appropriately reviewed by a suitably qualified clinician. The practice told us they were following the protocols developed for the pilot scheme and would discuss these issues with the local clinical commissioning group who had developed

the pilot. Following the inspection, the practice provided evidence of the improvements that had been considered and implemented.

Coordinating care and treatment

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

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

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	94.5%	94.1%	95.1%	No statistical variation

Exception rate (number of exceptions).	6.6% (144)	1.1%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes

Caring Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
CQC comments cards	
Total comments cards received.	19
Number of CQC comments received which were positive about the service.	19
Number of comments cards received which were mixed about the service.	nil
Number of CQC comments received which were negative about the service.	nil

Source	Feedback
Comment cards	All the CQC comment cards we received from patients were highly complementary of the service provided. Patients used words like, excellent and great to describe the service.
Patients verbal feedback	During our inspection we spoke to three patients they were very happy with the service and praised the practice staff for their caring approach and for providing a good service.

National GP Survey results – based on information for St Georges location prior to the merger of one service delivered by Fireclay Health.

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

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
22239	315	117	37.1%	0.53%
The practice had responded to the results of this survey by drafting a report which looked at the key findings and identified steps the practice could take to improve ratings.				

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	93.2%	90.4%	89.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018)	91.9%	88.6%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	95.6%	96.5%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	84.9%	84.5%	83.8%	No statistical variation

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

Involvement in decisions about care and treatment

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

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

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	93.0%	93.9%	93.5%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes

Privacy and dignity

The practice respected / did not always respect patients' privacy and dignity.

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

Responsive Rating: Good

Responding to and meeting people's needs

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

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

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	08:00-19:00
Tuesday	08:00-18:30
Wednesday	08:00-18:30
Thursday	08:00-18:30
Friday	08:00-18:30
Appointments available:	
Monday	08:30-18:30
Tuesday	08:30-19:00(nurse only from 18:30-19:00)
Wednesday	08:30-18:30
Thursday	08:30-18:30
Friday	08:30-20:00
The practice was working with other local practices to offer registered patients appointments in the early mornings (before 08.00), weekday evenings (between 18.30 and 20.00)) and at the weekends (Saturday/Sunday). Appointments take place either at St George Health Centre or at a nearby GP practice.	

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
22239	315	117	37.1%	0.53%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	93.7%	94.7%	94.8%	No statistical variation

Older people — Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients.

People with long-term conditions — Population group rating: Good

Findings

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

Families, children and young people — Population group rating: Good

Findings

- Additional nurse appointments were available until 7pm on a Monday for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 8.15pm on a Monday and Friday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available Saturday and Sunday 10am until 1pm.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

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

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- The practice was piloting a scheme which aimed to improve the pathways between primary and secondary care, so this is easier for patients. This scheme aimed to achieve this by improving GPs access to a Consultant Psychiatrist, having appointments with a registered mental health professional at the practice which could be booked by the GPs, and by having a suitably trained health care assistant who could see patients with low level mental health issues.

Timely access to the service

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

National GP Survey results – based on information for St Georges location prior to the merger of one service delivered by Fireclay Health.

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes
Additional evidence; The practice had a system for 'urgent, same day care' for patients throughout the times of usual working hours between 08:00 and 18:30. Patients requests were responded to on the day, they were triaged at the point of contact with the practice and referred to the most appropriate clinician or member of staff such as GP, ANP or pharmacist.	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	64.1%	N/A	70.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	65.9%	68.2%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	58.6%	64.9%	65.9%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	75.2%	75.3%	74.4%	No statistical variation

Any additional evidence or comments
The practice had responded to the results of this survey by drafting a report which looked at the key findings and identified steps the practice could take to improve ratings.

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	37
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	nil

	Y/N/Partial
Information about how to complain was readily available.	Partial (see below)
There was evidence that complaints were used to drive continuous improvement.	Yes

Explanation of any answers and additional evidence:

On the day of our inspection the information available to patients in the waiting area about how to make a complaint lacked clarity. We discussed this with the practice who took immediate steps to clarify this information and sent us evidence to confirm the improvements they had made the next day.

We found that some verbal complaints/ minor comments that the practice was able to resolve within 24 hours were dealt with appropriately. However, the practice was not providing written acknowledgement to the commentators/ complainants. The practice told us they were following national guidance (BMA Complaints Management) on this issue but accepted their process could be further improved to ensure patients were formally informed of the outcomes of the expression of concern. The practice took immediate steps to review their procedures and within 24 hours clarified to us they had amended their policy for the future. Verbal complaints were included in the complaints monitoring system to ensure that themes and trends were reviewed and addressed.

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

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: In April 2018, St George Health Centre merged with Lodgeside Surgery . The practice told us that since then they had been working to integrate the two practice systems and staff teams. We saw numerous examples of this work. For example, the practice had developed a single reception hub where all phone calls where answered and triaged. The practice told us there were a few areas which needed to be reviewed and merged, and they had plans in place to do this.	

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes

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 systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: In the past year, following a merger with another local practice, most of the practice governance systems had been reviewed and where necessary changed to ensure system worked equally across all	

sites. The practice told us they recognised there were a few areas where this work was not yet complete. On our inspection we found issues which the practice governance processes had not identified. For example, emergency medicines were out of date.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Additional information: Members of the management team and GPs were involved in the wider engagement in the local health system such as transformation groups and the Clinical Commissioning Group.	

Feedback from Patient Participation Group.

Feedback
The practice had an active an engaged Patient Participation Group (PPG) who met four times a year. There were terms of reference for this group. The PPG told us the practice always answered any questions they had and gave us numerous examples of how the practice had worked with them to improve the services they provided. For example, following feedback from the PPG, they remodelled the reception area to improve the privacy of conversations and they had sought feedback from the PPG about their new triage system and responded to this feedback.

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

Examples of continuous learning and improvement
The practice was in the process of conducting a pilot test for using an SMS text system to communicate with patients. Following an evaluation of the pilot, the practice would decide whether to adopt the system permanently.

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 Band	Z-score threshold
1	Significant variation (positive)	Z ≤-3
2	Variation (positive)	-3 < Z ≤ -2
3	No statistical variation	-2 < Z < 2
4	Variation (negative)	2 ≤ Z < 3
5	Significant variation (negative)	Z ≥3
6	No data	Null

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

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

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

Glossary of terms used in the data.

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