

# Care Quality Commission

## Inspection Evidence Table

### St Peter's Surgery (1-620746710)

Inspection date: 21 November 2018

Date of data download: 14 November 2018

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

## Safe

### Safety systems and processes

| Safeguarding   | Y/N |
|--|-----|
| There was a lead member of staff for safeguarding processes and procedures.  | Yes |
| Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff.  | Yes |
| Policies were in place covering adult and child safeguarding.  | Yes |
| Policies were updated and reviewed and 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 |
| Information about patients at risk was shared with other agencies in a timely way.   | Yes |
| Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients   | Yes |
| Disclosure and Barring Service checks were undertaken where required   | Yes |
| <p>The practice maintained registers of children on child protection plans, as well as looked after children. The practice had made 11 child safeguarding referrals during the last year, and provided 29 reports for case conferences.</p> <p>The safeguarding policies had not been updated to reflect the change in safeguarding lead in the practice. Updated policies were provided the day after the inspection.</p> |     |

| Recruitment Systems   | Y/N |
|---|-----|
| 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.   | No  |
| Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.  | Yes |
| Staff who require medical indemnity insurance had it in place   | Yes |
| <p>Explanation of any answers:</p> <p>Newly recruited staff completed occupational health forms, although it was not clear if the information recorded on the forms was followed up.</p> <p>Complete records of staff immunisation status were not available at the time of the inspection.</p> |     |

| Safety Records  | Y/N |
|---|-----|
| There was a record of portable appliance testing or visual inspection by a competent person<br>Date of last inspection/Test: March 2018     | Yes |
| There was a record of equipment calibration<br>Date of last calibration: March 2018   | Yes |
| Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals                           | Yes |
| Fire procedure in place   | Yes |
| Fire extinguisher checks  | Yes |
| Fire drills and logs  | Yes |
| Fire alarm checks   | Yes |
| Fire training for staff   | Yes |
| Fire marshals   | Yes |
| Fire risk assessment<br>Date of completion: July 2018   | Yes |
| Actions were identified and completed.<br>Two areas for action were identified and these were completed in August 2018.                     | Yes |
| <b>Health and safety</b><br>Premises/security risk assessment?<br>Date of last assessment: January 2014 with updates – last dated May 2018. | Yes |
| Health and safety risk assessment and actions<br>Date of last assessment: January 2014 with updates – last dated May 2018.                  | Yes |

| Infection control   | Y/N |
|---|-----|
| Risk assessment and policy in place<br>Date of last infection control audit: April 2018<br>The practice acted on any issues identified<br><br>Detail: Eight points of action were highlighted and there was an ongoing programme in place to address these. | Yes |
| The arrangements for managing waste and clinical specimens kept people safe?  | Yes |

### Risks to patients

| Question   | Y/N |
|--|-----|
| There was an effective approach to managing staff absences and busy periods.   | Yes |
| Comprehensive risk assessments were carried out for patients.  | Yes |
| Risk management plans were developed in line with national guidance.   | Yes |
| Staff knew how to respond to emergency situations.   | 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 |
| In addition, there was a process in the practice for urgent clinician review of such patients.   | Yes |
| The practice had equipment available to enable assessment of patients with presumed sepsis.  | Yes |
| There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.  | Yes |
| <p>Staffing rotas were in place and reception staff told us that they covered holidays and sickness by working additional hours. They commented that this had been a challenge over recent months due to staff shortages. However, they told us the recently appointed business manager had addressed the issue and additional staff had been recruited.</p> <p>There had been changes to the staff team since our previous inspection in July 2015. The practice had successfully recruited an additional GP partner in May 2017. The senior partner had retired in July 2018, although they still worked one session a week in a locum capacity. There had also been some turnover of reception staff and the health care assistant. The long serving practice manager retired in August 2018 and the practice had appointed an experienced practice business manager as a replacement.</p> <p>A part time advanced nurse practitioner with paediatric experience and a newly qualified nurse were due to join the team in January 2019. The practice acknowledged they still had a vacancy for an additional health care assistant.</p> |     |

## Information to deliver safe care and treatment

| Question  | Y/N |
|---|-----|
| Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.  | Yes |
| Referral letters contained specific information to allow appropriate and timely referrals.  | Yes |
| Referrals to specialist services were documented.   | Yes |
| The practice had 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 |
| The practice participated in peer to peer review of all referrals to ensure they were appropriate. The practice was below the CCG average for the number of referrals made.         |     |

## Appropriate and safe use of medicines

| Indicator  | Practice | CCG average | England average | England comparison              |
|--|----------|-------------|-----------------|---------------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2017 to 30/06/2018) NHS Business Service Authority - NHSBSA)                                | 1.06     | 1.01        | 0.95            | Comparable with other practices |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2017 to 30/06/2018) (NHSBSA) | 8.2%     | 5.4%        | 8.7%            | Comparable with other practices |

| Medicines Management  | Y/N |
|---|-----|
| 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 |
| Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).  | Yes |
| Prescriptions (pads and computer prescription paper) were kept securely and monitored.  | Yes |
| There was a process for the management 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 audits for 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 systems for the safe ordering, checks on receipt, storage, administration, balance checks and disposal of these medicines in line with national guidance. | NA  |
| Up to date local prescribing guidelines were in use.  | Yes |
| Clinical staff were able to access a local microbiologist for advice.   | Yes |
| For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance.   | NA  |
| The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.  | Yes |
| The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.  | Yes |
| There was medical oxygen on site.   | Yes |
| The practice had a defibrillator.   | Yes |
| Both were checked regularly and this was recorded.  | Yes |

|  |     |
|--|-----|
| Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.  | Yes |
| <p>There was as structured system in place for checking the emergency medicines held in the practice and in the GP bags. We spoke with the health care assistant regarding recording each time the GP bags were checked, rather than just monthly, and when they provided the GPs with medicines to replace stock going out of date.</p> <p>The practice had reviewed the use of opioids in chronic non-cancer pain and sought advice from the local pain consultant. The practice identified 75 patients prescribed one or a combination of four different medicines. In addition, 33 patients were prescribed oral morphine solution. Following advice from the pain consultant, the practice planned to try and reduce usage of oral morphine solution.</p> |     |

## Track record on safety and lessons learned and improvements made

| Significant events  | Y/N |
|---|-----|
| There was a system for recording and acting on significant events       | Yes |
| Staff understood how to 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.                            | 11  |
| Number of events that required action                                   | 10  |

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

| Event   | Specific action taken  |
|---|--|
| A patient had collapsed with reduced level of consciousness in the surgery twice in a day after smoking an illegal high.              | The staff's response to an emergency was reviewed following the collapse of a patient at the practice. The findings were that all staff had responded promptly to the incidents and the team worked effectively. The GPs present identified there was learning needed regarding whether to give naloxone injection.<br><br>Following the incident, the doctors were issued with guidance on when to administer naloxone. |
| Patients complained that envelopes containing confidential patient information for online access were found to be open when delivered | The practice reviewed the situation and decided to continue to post out letters for online access with all parts in one letter. This was because it was a time limited process linked to changing the electronic system. However, a decision was made to double seal the envelopes with tape. A further review would be undertaken at the next meeting to see if any further complaints had been received.               |

| Safety Alerts  | Y/N |
|--|-----|
| There was a system for recording and acting on safety alerts   | Yes |
| Staff understand how to deal with alerts   | Yes |
| <p>Comments on systems in place:</p> <p>Alerts were received electronically and disseminated to clinical staff. All alerts were recorded on a register, which detailed the alert and the action taken. We saw that the practice had responded appropriately to a recent medicine alert, by identifying all patients prescribed the medicine and writing to them.</p> |     |

| Any additional evidence   |
|---|
| The practice described the action they had taken in respect of two previous safety alerts. The first related to the risk that sodium valproate represented to unborn babies. This alert was initially received in 2016. The practice identified all female patients of child bearing age prescribed this medication and |

had sent them a letter including an information leaflet. The alert was updated and reissued during 2018. A further search was carried out, and letters and information sent to patients.

The practice was notified in August 2018 by NHS England of a measles outbreak. The practice searched for all patients who had never received the MMR vaccine or had only received one dose. The practice also screened all new patient registrations to check whether they were up to date with their MMR vaccines. Identified patients were invited to make an appointment for their vaccines. The campaign was still ongoing and to date, 11 patients had received the vaccine.



# Effective

## Effective needs assessment, care and treatment

| Prescribing  |                      |             |                 |                                 |
|--|----------------------|-------------|-----------------|---------------------------------|
| Indicator  | Practice performance | CCG average | England average | England comparison              |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2017 to 30/06/2018) (NHSBSA) | 0.55                 | 0.77        | 0.83            | Comparable with other practices |

## People with long-term conditions

| Diabetes Indicators  |  |                    |                        |                                 |
|--|--|--------------------|------------------------|---------------------------------|
| Indicator  | Practice performance                           | 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)                        | 84.6%  | 78.4%              | 78.8%                  | Comparable with other practices |
| QOF Exceptions   | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|  | 21.1% (151)                                    | 11.3%              | 13.2%                  |                                 |
| Indicator  | Practice performance                           | CCG average        | England average        | England comparison              |
| 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) | 84.0%  | 81.1%              | 77.7%                  | Comparable with other practices |
| QOF Exceptions   | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|  | 10.2% (73)                                     | 6.3%               | 9.8%                   |                                 |

| Indicator   | Practice performance                           | CCG average        | England average        | England comparison              |
|---|--|--------------------|------------------------|---------------------------------|
| The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF) | 86.8%  | 81.2%              | 80.1%                  | Comparable with other practices |
| <b>QOF Exceptions</b>   | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|   | 15.1% (108)                                    | 9.5%               | 13.5%                  |                                 |

| Other long term conditions   |  |                    |                        |                                 |
|--|--|--------------------|------------------------|---------------------------------|
| Indicator  | 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)          | 72.9%  | 77.4%              | 76.0%                  | Comparable with other practices |
| <b>QOF Exceptions</b>  | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|  | 1.3% (8)                                       | 2.5%               | 7.7%                   |                                 |
| Indicator  | Practice                                       | CCG average        | England average        | England comparison              |
| 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) | 87.8%  | 91.9%              | 89.7%                  | Comparable with other practices |
| <b>QOF Exceptions</b>  | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|  | 19.9% (59)                                     | 8.5%               | 11.5%                  |                                 |

| Indicator  | Practice                                       | CCG average        | England average        | England comparison              |
|--|--|--------------------|------------------------|---------------------------------|
| The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>   | 83.8%  | 84.1%              | 82.6%                  | Comparable with other practices |
| <b>QOF Exceptions</b>  | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|  | 3.1% (35)                                      | 2.8%               | 4.2%                   |                                 |
| Indicator  | Practice                                       | CCG average        | England average        | England comparison              |
| In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) <small>(QOF)</small>                                   | 87.3%  | 90.4%              | 90.0%                  | Comparable with other practices |
| <b>QOF Exceptions</b>  | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|  | 2.9% (4)                                       | 4.8%               | 6.7%                   |                                 |
| <b>Any additional evidence or comments</b>   |  |                    |                        |                                 |
| <p>The practice was aware that their exception reporting for a number of clinical domains was above average. They planned to review the exception reporting criteria and the lead GP and nurse lead to work together to review the data and take appropriate action.</p> |  |                    |                        |                                 |

## Families, children and young people

| Child Immunisation  |           |             |            |   |
|---|-----------|-------------|------------|---|
| Indicator   | 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)  | 143       | 147         | 97.3%      | Met 95% WHO based target (significant variation positive) |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)   | 123       | 135         | 91.1%      | Met 90% minimum (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)   | 121       | 135         | 89.6%      | Below 90% minimum (variation negative)                    |
| 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)  | 124       | 135         | 91.9%      | Met 90% minimum (no variation)                            |
| <b>Any additional evidence or comments</b>  |           |             |            |   |
| <p>There was a lead GP and nurse lead with responsibility for child health and childhood immunisations. The practice held a weekly joint GP and nurse led 'baby assessment and immunisation' clinic. Systems were in place to follow up children who did not attend for appointments.</p> |           |             |            |   |

Working age people (including those recently retired and students)

| <b>Cancer Indicators</b>  |                 |                    |                        |                                 |
|---|-----------------|--------------------|------------------------|---------------------------------|
| <b>Indicator</b>  | <b>Practice</b> | <b>CCG average</b> | <b>England average</b> | <b>England comparison</b>       |
| 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) (01/04/2016 to 31/03/2017) (Public Health England)  | 63.2%           | 71.8%              | 72.1%                  | Comparable with other practices |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)   | 58.2%           | 68.6%              | 70.3%                  | N/A                             |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE)   | 43.3%           | 49.0%              | 54.6%                  | 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. (PHE)   | 64.0%           | 76.2%              | 71.3%                  | N/A                             |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE)   | 64.9%           | 44.1%              | 51.6%                  | Comparable with other practices |
| <b>Any additional evidence or comments</b>  |                 |                    |                        |                                 |
| <p>The practice staff were aware of the screening results for cervical, breast and bowel cancer screening. They aimed to improve the results for cervical screening through posters, information leaflets (including in a range of different languages), working closely with the cervical cytology outreach nurse to provide additional appointments and opportunistic verbal encouragement in consultations. The practice actively followed up patients who did not respond to the bowel screening invitation and had improved the uptake of screening over the previous three years.</p> |                 |                    |                        |                                 |

People experiencing poor mental health (including people with dementia)

| Mental Health Indicators  |  |                    |                        |                                 |
|---|--|--------------------|------------------------|---------------------------------|
| Indicator   | 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%  | 92.5%              | 89.5%                  | Comparable with other practices |
| QOF Exceptions  | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|   | 16.2% (17)                                     | 7.8%               | 12.7%                  |                                 |
| Indicator   | Practice                                       | CCG average        | England average        | England comparison              |
| 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)   | 92.7%  | 93.8%              | 90.0%                  | Comparable with other practices |
| QOF Exceptions  | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|   | 8.6% (9)                                       | 4.7%               | 10.5%                  |                                 |
| Indicator   | Practice                                       | CCG average        | England average        | England comparison              |
| 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)   | 93.5%  | 82.7%              | 83.0%                  | Comparable with other practices |
| QOF Exceptions  | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|   | 8.0% (4)                                       | 6.0%               | 6.6%                   |                                 |
| <b>Any additional evidence or comments</b>  |  |                    |                        |                                 |
| <p>The practice were aware that their exception reporting for mental health QOF indicators was above average and action was being taken to address this. For example: reminder letters for annual reviews were being sent out earlier in the year to allow more time to follow up patients and book appointments. The health care assistant was actively contacting patients by telephone to book appointments for blood tests and blood pressure checks. In addition, the practice was working closely with the support worker from the local hostel for male patients with mental health needs to encourage patients to attend for reviews.</p> |  |                    |                        |                                 |

## Monitoring care and treatment

| Indicator                                     | Practice | CCG average | England average |
|---|----------|-------------|-----------------|
| Overall QOF score (out of maximum 559)        | 98.5%    | 95.2%       | 96%             |
| Overall QOF exception reporting (all domains) | 12.4%    | 8.3%        | 9.7%            |

## Coordinating care and treatment

| Indicator  | Y/N |
|--|-----|
| 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 |

## Helping patients to live healthier lives

| 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) | 96.1%  | 97.2%              | 95.1%                  | Comparable with other practices |
| QOF Exceptions   | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |                                 |
|  | 0.0% (1)                                       | 0.3%               | 0.8%                   |                                 |

## Consent to care and treatment

| Description of how the practice monitors that consent is sought appropriately  |
|--|
| <p>The practice staff documented consent within their electronic systems and with written consent forms for minor surgical procedures.</p> <p>Staff were in receipt of Mental Capacity Act (MCA) training and Deprivation of Liberty Safeguards (DoLS).</p> <p>Staff we met were had a clear understanding and awareness of capacity, best interest decisions and of Gillick competencies.</p> <p>The practice had started to document patient expressed choices such as preferred place of death and review whether these had been met. However, the practice recognised that recording this information was an area for improvement.</p> |

# Caring

## Kindness, respect and compassion

| CQC comments cards  |    |
|---|----|
| Total comments cards received   | 22 |
| Number of CQC comments received which were positive about the service | 16 |
| Number of comments cards received which were mixed about the service  | 2  |
| Number of CQC comments received which were negative about the service | 4  |

Examples of feedback received:

| Source                                  | Feedback   |
|---|--|
| CQC Comment Cards                       | Twenty-two comment cards were completed by patients. Sixteen cards contained positive comments about the service provided. Staff were described as caring, kind and respectful. The negative comments related to challenges getting an appointment and waiting times.  |
| NHS Choices                             | Four reviews had been posted on NHS Choices since March 2017. The practice responded to both positive and negative comments. Two patients rated their positive experience as five star and one rated their experience as three star. Patients reported positively on the staff and the care and treatment they had received. One patient rated their experience as one star. Both this patient and the patient who rated their experience as three star commented on the difficulty in accessing appointments. These comments related to March 2017. |
| Healthwatch Walsall Experience Exchange | A total of 10 comments had been left on the Healthwatch Walsall Experience Exchange website. Six of these comments reported positively about the practice and how they had been treated by staff. Two comments made in November 2017 reported negatively about accessing appointments and GPs running late. Two related comments made in August 2018 commented on the difficulties of registering as a temporary patient.  |



## National GP Survey results

**Note:** The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology has changed in 2018. This means that we cannot be sure whether the change in scores was due to the change in methodology, or was due to a genuine change in patient experience.

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 9770                     | 371              | 91               | 24.5%                 | 0.93%                    |

| 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)                   | 87.0%    | 86.3%       | 89.0%           | Comparable with other practices |
| 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) | 88.1%    | 85.3%       | 87.4%           | Comparable with other practices |
| 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)                              | 97.4%    | 94.8%       | 95.6%           | Comparable with other practices |
| 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)   | 79.0%    | 81.1%       | 83.8%           | Comparable with other practices |

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

| Date of exercise | Summary of results  |
|------------------|---|
| March 2018       | The practice had asked patients to complete the general practice assessment questionnaire (GPAQ). A total of 62 questionnaires were completed and the majority of the practice results were above GPAQ benchmark score. |

| Any additional evidence  |
|--|
| <p>In conjunction with the patient representative group (PRG) the practice had reviewed a range of information on an annual basis. This included a review of internal and third party audits, summary of analysis and key issues identified by the PRG, family and friends test, national patient experience survey and practice general practice assessment questionnaire (GPAQ). The previous action plan was also reviewed.</p> <p>The issues identified from the review had been incorporated into an action plan which included reception and telephone access, appointment access and on-line services and development of the PRG. The action plan was reviewed and updated at each PRG meeting.</p> |

## Involvement in decisions about care and treatment

Examples of feedback received:

| Source                                  | Feedback  |
|---|---|
| CQC Comments cards                      | Positive comments included that the GPs listened to any thoughts and opinions that patients had about their care; that any concerns they had were answered; and doctors were compassionate about patient wants and needs. |
| Healthwatch Walsall Experience Exchange | One patient commented positively on the Healthwatch Walsall Experience Exchange about a member of clinical staff explaining about their long-term condition.  |
| NHS Choices                             | One patient commented positively about the service provided by the GPs. They said they were attentive, listened and gave sound advice.  |

## 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) | 88.6%    | 91.3%       | 93.5%           | Comparable with other practices |

| Question  | Y/N |
|---|-----|
| 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 easy read format.  | Yes |
| Information about support groups was available on the practice website.   | Yes |

| Carers                                     | Narrative   |
|--|---|
| Percentage and number of carers identified | The practice population on the day of the inspection was 9782 and the carer number was 119. This represented 1.2% of the practice population.   |
| How the practice supports carers           | All newly identified carers were sent a letter informing them that were eligible for an annual health check and flu vaccination. Staff signposted carers to available services, for example Walsall Carers Centre. Carers were coded on the electronic notes and invited for their annual check and |

|  |  |
|--|--|
|  | vaccination. One of the GP partners had taken on the responsibility of lead role for carers. |
| How the practice supports recently bereaved patients | The practice sent out information packs to bereaved patients.                                |

### Any additional evidence

The practice has sourced information leaflets in a range of languages.

### Privacy and dignity

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

|  | Narrative   |
|--|---|
| Arrangements to ensure confidentiality at the reception desk | The chairs were located away from the reception desk. Telephone calls were answered away from the reception desk. |

| Question  | Y/N |
|---|-----|
| 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 |

Examples of specific feedback received:

| Source                | Feedback   |
|-----------------------|--|
| Interviews with staff | Staff told us that if the consulting room was closed, other staff always knocked and waited to be invited into the room. |

# Responsive

## Responding to and meeting people's needs

| Practice Opening Times |                    |
|------------------------|--------------------|
| Day                    | Time               |
| Monday                 | 8.30 am to 6.30 pm |
| Tuesday                | 8.30 am to 6.30 pm |
| Wednesday              | 8.30 am to 6.30 pm |
| Thursday               | 8.30 am to 6.30 pm |
| Friday                 | 8.30 am to 6.30 pm |

The practice was accessible by telephone between 8am and 6.30pm every weekday.

| Extended hours opening  |
|---|
| <p>7.30am to 8am every Monday, Tuesday and Thursday – appointments were available with GPs, a practice nurse and the health care assistant.</p> <p>Patients also had access to the Extended GP Access Service. Appointments with GPs were available at four hubs within the locality: Darlaston Health Centre, Pinfold Health Centre, Broadway Medical Practice and Portland Medical Practice.</p> <p>Extra GP appointments were available between:</p> <ul style="list-style-type: none"> <li>• 6.30pm – 9pm weekdays (all four hubs)</li> <li>• 10am – 3pm weekends (excluding Darlaston Health Centre &amp; Portland Medical Practice)</li> <li>• 11am – 1.30pm Bank Holidays (all four hubs)</li> </ul> <p>Appointments could be booked by calling 01922 501999 during the following times:</p> <ul style="list-style-type: none"> <li>• 8am – 9pm weekdays</li> <li>• 10am – 3pm weekends</li> <li>• 11am – 1.30pm bank holidays</li> </ul> <p>NHS 111 were also able to book appointments for patients.</p> |

| Home visits   | Y/N |
|---|-----|
| The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention | Yes |

**If yes, describe how this was done**

Home visits were booked following a clinical decision and assessment by the duty GP and visits divided amongst the GPs. The duty doctor was available to staff for advice.

## National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 9770                     | 371              | 91               | 24.5%                 | 0.93%                    |

| 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) | 93.2%    | 93.9%       | 94.8%           | Comparable with other practices |

## Timely access to the service

### National GP Survey results

| 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)  | 54.7%    | 71.2%       | 70.3%           | Comparable with other practices |
| 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)  | 68.1%    | 66.8%       | 68.6%           | Comparable with other practices |
| 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)   | 66.8%    | 64.9%       | 65.9%           | Comparable with other practices |
| 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)  | 70.9%    | 70.7%       | 74.4%           | Comparable with other practices |
| <p><b>Any additional evidence or comments</b></p> <p>The practice had acknowledged that patient satisfaction in relation to getting through to the practice by phone was lower than local and national averages and had developed an action plan to improve patient satisfaction. The practice continued to monitor how quickly telephone calls were answered, and were in the process of installing an additional telephone line.</p> |          |             |                 |                                 |

### Examples of feedback received from patients:

| Source                  | Feedback   |
|-------------------------|--|
| Interview with patients | Patients told us they were able to get an appointment when they needed one.  |
| CQC Comment Cards       | The two comment cards, with mixed views about the service, made reference to the challenges around making an appointment, especially outside of work hours. One of the cards with negative comments said it was difficult to get through to the practice on the telephone. |
| NHS Choices             | Four comments had been posted on NHS Choices since March 2017. The practice responded to both positive and negative comments. Two patients commented on the difficulty in accessing appointments, especially for working patients. These comments related to March 2017.   |
| Healthwatch             | A total of 10 comments had been left on the Healthwatch Walsall Experience   |

|                                   |   |
|-----------------------------------|---|
| Walsall<br>Experience<br>Exchange | Exchange website. Two comments made in November 2017 reported negatively about accessing appointments and GPs running late. Two related comments made in August 2018 commented on the difficulties of registering as a temporary patient. |
|-----------------------------------|---|



## Listening and learning from complaints received

| Complaints  | Y/N |
|---|-----|
| Number of complaints received in the last year.   | 20  |
| 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   | 1   |
| Additional comments:  |     |
| The practice provided complaints and comments literature for patients which were available in the waiting room and on the practice website. |     |

### Example of how quality has improved in response to complaints

Any learning from complaints was identified and shared with staff during the business meetings. All complaints were reviewed on an annual basis to identify any trends or themes. The majority of complaints received during the previous 12 months related to access. As a consequence the practice had organised for an additional telephone line to be installed.

### Any additional evidence

The practice was IRIS (Identification and Referral to Improve Safety) trained. IRIS training enabled GPs to identify patients affected by domestic violence and abuse and refer them to specialist services. Since completion of the training eleven referrals relating to domestic violence had been made.

The practice operated a flagging system for patients with special communication needs. The alert on the electronic system stated 'Please note, this patient has a sensory impairment – accessible information standard requirements. The new patient questionnaire asked patients if they had any sensory difficulties. If any difficulties were identified then staff completed a template detailing the preferred method of communication, as well as the font size needed for visually impaired patients. The template included a section on carers, if applicable. The practice had recently included a paragraph on all patient letters asking patients if they would like the letter in an alternative format and/or help with communication needs to inform staff.

# Well-led

## Leadership capacity and capability

### Examples of how leadership, capacity and capability were demonstrated by the practice

We found there was compassionate, inclusive and effective leadership at all levels. The practice demonstrated high levels of experience, capacity and capability. There was an embedded system of leadership development and succession planning, which aimed to ensure that the leadership represented the diversity of the workforce. The practice management had a deep understanding of issues, challenges and priorities in their service, and beyond.

The practice participated in the Productive General Practice Quick Start Programme organised by the Clinical Commissioning Group. This programme had assisted the practice to implement a workflow management system which had reduced the paper workload for GPs.

The practice had successfully applied for resilience funding from NHS England. This had assisted the practice with the recruitment of new practice business manager, and also funding locum sessions to release GP partners to develop the practice and make it more resilient. This had enabled the practice to strengthen the clinical leadership through the development of lead roles for clinicians, with protected time in finance, transformation, education and quality and training.

### Any additional evidence

The practice had an action plan to meet the needs of its registered population whilst bearing in mind the aims and objectives of the wider health economy. These included for example:

- A QOF action plan
- Patient engagement, through surveys, and via the PRG
- A regular analysis of significant events and complaints to identify any common trends, maximise learning and help mitigate further errors.
- Ensuring health and safety checks were undertaken at the recommended timescales.
- A review of data provided by the CCG, including prescribing data.

## Vision and strategy

### Practice Vision and values

The ethos of the practice was based around the word 'team' – together everyone achieves more. This included being caring and compassionate, providing evidence based, person centred care, delivering training to future GPs and Foundation Doctors with a learning environment for all staff. This was all based around team work.

## Culture

### Examples that demonstrate that the practice has a culture of high-quality sustainable care

There was a strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and patient's experiences. This included staff involvement and engagement with the practice audit on changes for a better future and their opinions which helped to direct the practice wide solutions which were implemented.

There were good levels of satisfaction across all staff groups with a strong organisational commitment towards ensuring that there is equality and inclusion across the workforce. When asked staff responded that they were most proud of the practice team. They were proud of the practice as a place to work and spoke highly of the culture.

Staff at all levels were encouraged to speak up and raise concerns. Staff reported that they would raise any concerns freely and would be supported to do so by the practice management and GPs. Staff reported they felt respected and valued.

The practice had introduced protected practice education sessions (PES) from January 2018. Topics for sessions included pain management, inhaler techniques, input from mental health services, IMPACT training on antibiotics, duty of candour training, update of care of patients with a learning disability and IRIS training.

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

| Source                                 | Feedback  |
|--|---|
| Staff                                  | Staff had opportunities to meet as a whole team. This enabled communication with staff to ensure they all received consistent information and had opportunities to feedback any ideas and areas for improvement.  |
| Patient Representative Group           | The PRG enabled the practice to discuss developments with patient representatives and to receive feedback to support changes within the service.<br><br>The PRG helped the practice to develop the action plan to address the issues identified through the surveys and quality assurance work. |
| External: Clinical Commissioning Group | The practice worked to achieve CCG led initiatives supporting service improvement aimed at improving patient care.<br><br>The three priority targets were better control of blood pressure, diabetes and cholesterol.   |
| External: Community teams              | The practice met regularly with the community teams such as District Nurses, Palliative Care Nurses and substance misuse workers to co-ordinate and plan care to some of the practice's most vulnerable patients.   |

## Governance arrangements

### Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.

|   |  |
|---|--|
| Practice specific policies                              | Yes  |
| Other examples  | <p>There were clear lines of accountability in relation to administrative workflow processes, safeguarding, infection control, recall systems, performance data and clinical governance.</p> <p>The implementation of the workflow management system and electronic storage system 'Intrado', where information was readily accessible and catalogued.</p> <p>The practice management demonstrated clear governance arrangements, for example monitoring health and safety, receipt of patient safety alerts and monitoring of complaints and incidents.</p> <p>Staff reported they had clarity around their roles and the governance arrangements in place.</p> |
|   |  |
|   | <b>Y/N</b>   |
| Staff were able to describe the governance arrangements | Yes  |
| Staff were clear on their roles and responsibilities    | Yes  |

### Any additional evidence

The practice held meetings to discuss incidents and events, complaints and governance issues of which there were minutes available for staff to access. These included:

- Practice education sessions held every six to eight weeks.
- Business meetings held every three weeks.
- Reception staff meetings.
- Administrative team meetings.
- Nurse meetings.
- Whole practice meetings.
- PRG meetings.
- Appraisals and revalidation.
- Multidisciplinary team meetings.
- Meetings, supervision and training with GP trainees.

### Managing risks, issues and performance

|   |            |
|---|------------|
| <b>Major incident planning</b>                  | <b>Y/N</b> |
| Major incident plan in place                    | Yes        |
| Staff trained in preparation for major incident | Yes        |

Examples of actions taken to address risks identified within the practice

|             |  |
|-------------|--|
| <b>Risk</b> | <b>Example of risk management activities</b> |
|-------------|--|

|  |   |
|--|---|
| Infection Prevention and Control (IPC) | An external audit had been completed on the practice IPC and an action plan was derived from its findings. The practice had reviewed the action plan and were progressing through the areas identified for improvement.                         |
| Fire drills                            | Fire drills had been completed and documented. The practice staff had completed fire safety training.   |
| Business Plan 2018 / 2020              | The business plan contained a number of objectives to address identified risks. These included the recruitment of additional clinical staff, dedicated educational time, increased telephone lines and installation for new electronic systems. |

## Appropriate and accurate information

| Question  | Y/N |
|---|-----|
| Staff whose responsibilities include making statutory notifications understood what this entails. | Yes |

| Any additional evidence   |
|---|
| The registration had not been updated following the retirement of one of the GP partners. |

## Engagement with patients, the public, staff and external partners

### Feedback from Patient Participation Group;

| Feedback   |
|--|
| <p>The Patient Representation Group (PRG) attended regular three monthly meetings at the practice. They reported that the practice listened to views whether positive or negative. They told us the practice discussed survey results with them, and they were involved in developing the action plan to address the issues identified.</p> <p>One of the GP partners sat on the CCG Board and was also the chair for the South Locality.</p> <p>The practice was engaging with the support worker at a local hostel to encourage patients to attend for their annual reviews.</p> |

## Continuous improvement and innovation

Examples of improvements demonstrated as a result of clinical audits in past two years

| Audit area  | Improvement  |
|---|--|
| National Cancer Diagnosis Audit (NCDA) January 2017. This is a national audit where practice review all cancer diagnoses from 2014 and upload data on to a national database. | <p>At total of 17042 cancer cases were reviewed, of which 47 cases related to the practice. Overall the data for the practice was better than the England average, although the practice had identified lessons to be learnt. These included:</p> <ul style="list-style-type: none"> <li>• Two week wait referrals should be used if patients met the criteria.</li> <li>• Increase awareness of PSA levels (possible indicator for prostate cancer) in different age groups, and use a two week wait referral if outside of normal range.</li> <li>• Consider certain blood tests if patients present with urinary symptoms or new onset abdominal symptoms including abdominal pain and bloating.</li> </ul> <p>The lead Macmillan GP facilitator in the practice presented the results to the practice and individual GPs also received individual feedback</p> |

|  |   |
|--|---|
|  | about cases they were involved in.  |
| Use of Proton Pump Inhibitors (PPI) which are medicines which reduce the amount of acid made by your stomach in patients prescribed Naproxen (a non steroidal anti-inflammatory medicine) with gastro-intestinal (GI) risk factors | <p>The practice carried out this audit in response to a significant event of a patient with a perforated ulcer on naproxen but not prescribed a PPI.</p> <p>The practice had set a standard around prescribing PPIs to patients on naproxen with GI risks. The audit demonstrated that the practice had achieved the standard set. The patients identified in the first and second audit cycles had their medication reviewed and updated and the standard was achieved by the third audit cycle.</p> |
| Audit of patients with chronic kidney disease (CKD) on metformin (a medicine prescribed for type 2 diabetes)   | NICE guidance on Type 2 diabetes issued in May 2009 advised that whether metformin should be prescribed / dose reviewed should be linked to certain blood results (creatinine levels). The guidance was used to define the standards to be met and the audit demonstrated that these had been achieved. The practice had carried out three audit cycles in 2009, 2012 and August 2017. The third audit cycle demonstrated improvement and achievement of the standard set.                            |

### Any additional evidence

The practice completed various audits as part of an ongoing quality improvement audit programme. These included for example:

- Audit on re-authorisation of repeat medications when seen by GP Partners in 2016 and 2018
- GP workflow audit
- Electronic referral system (ERS) data monitoring
- 2WW referral data monitoring
- Clinical correspondence workflow audit
- Review of the use of opioid medicine in chronic non- cancer pain
- Minor surgery

The practice was participating in the Macmillan Cancer Champion project. A member of reception staff acted as a non-clinical cancer champion and actively signposted patients to available services. One of the practice nurses was trained to undertake enhanced cancer care reviews. One of the GP partners was the Macmillan GP Facilitator.

### Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to

the average, but still shows as comparable, 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 comparable to other practices.

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

The following language is used for showing variation:

|   | Variation Band                   | Z-score threshold |
|---|----------------------------------|-------------------|
| 1 | Significant variation (positive) | $Z \leq -3$       |
| 2 | Variation (positive)             | $-3 < Z \leq -2$  |
| 3 | Comparable to other practices    | $-2 < Z < 2$      |
| 4 | Variation (negative)             | $2 \leq Z < 3$    |
| 5 | Significant variation (negative) | $Z \geq 3$        |
| 6 | No data                          | Null              |

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.

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: <http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices>

#### Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework (see <https://qof.digital.nhs.uk/>).
- **RCP:** Royal College of Physicians.
- **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. ( [See NHS Choices for more details](#)).