

Care Quality Commission

Inspection Evidence Table

All Saints Surgery (1-570735489)

Inspection date: 22 January 2019

Date of data download: 09 January 2019

Overall rating: Requires Improvement

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

Safe

Rating: Requires Improvement

Safety systems and processes

We rated the practice as requires improvement for providing safe services because:

- The practice did not have a system in place that demonstrated that alerts with may affect patient safety had been received, recorded and acted upon.
- The practice could not demonstrate that patients' health in relation to the use of medicines including high risk medicines was appropriately monitored and clinical review took place prior to prescribing.

The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

| Safeguarding | Y/N/Partial |
|---|-------------|
| There was a lead member of staff for safeguarding processes and procedures. | Yes |
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Yes |
| There were policies covering adult and child safeguarding. | Yes |
| Policies took account of patients accessing any online services. | Yes |
| Policies and procedures were monitored, reviewed and updated. | Partial |
| Policies were accessible to all staff. | Partial |
| 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 |

| Safeguarding | Y/N/Partial |
|---|-------------|
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Yes |
| Staff who acted as chaperones were trained for their role. | Yes |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Partial |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice told us they invited the health visiting team to their monthly clinical meetings, although they rarely attended due to the demands on their service. However, clinicians told us they could contact the health visitors at any time to discuss any concerns and share information. • Policies and procedures had been stored electronically in a number of different places. The practice acknowledged that this had created challenges for staff accessing policies. The practice was in the process of moving policies and procedures to a central repository (Compliance Manager). • The practice maintained a register of children with child protection plans as well as looked after children. We saw that both lists contained patients over 18 years old. These patients had not been transferred over to the vulnerable adults register. | |

| 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 |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We saw that the staff recruitment files were well organised. | |

| 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: October 2018 | Yes |
| There was a record of equipment calibration. Date of last calibration: October 2018 | Yes |
| There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals. | Partial |
| There was a fire procedure. | Yes |
| There was a record of fire extinguisher checks. Date of last check: 2018 | Yes |
| There was a log of fire drills. Date of last drill: Unplanned in August 2018 | Yes |
| There was a record of fire alarm checks. Date of last check: 22/01/2019 – weekly | Yes |
| There was a record of fire training for staff. Date of last training: Individual dates as part of e-learning | Yes |
| There were fire marshals. | Yes |
| A fire risk assessment had been completed. Date of completion: July 2018 | Yes |
| Actions from fire risk assessment were identified and completed. | Yes |
| Explanation of any answers and additional evidence: | |

| Health and safety | Y/N/Partial |
|---|-------------|
| Premises/security risk assessment had been carried out. Date of last assessment: 2016 | Partial |
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 2016 | Partial |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had a COSHH self-assessment detailing the products in each room and data sheets were also available. There was no overall COSHH risk assessment. • NHS Walsall IT Department was responsible for the portable appliance testing of equipment owned by them. • A Health, Safety and Security and Fire Inspection had been completed by NHS Estates in 2016 and an action log generated. A number of the items on the action log remained open so it was not clear if the actions had been addressed or not. | |

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: December 2017 (Field Road Surgery) | 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. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The Infection Protection and Control (IPC) team from the local authority planned to visit the practice on 13 January 2019 to carry out an audit. | |

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 |
| Explanation of any answers and additional evidence: | |

- The practice was actively recruiting to two vacant reception staff posts.
- The GPs had attended training on sepsis and posters were on display in consulting rooms.
- Sepsis guidance was available for reception staff. Staff spoken with were aware of the symptoms to ask about and/or observe for and the action to take.
- A patient made positive comments on a CQC comment card regarding the care provided to their relative who had been diagnosed with suspected sepsis. They said that staff treated them both with dignity and respect whilst they waited for the ambulance to arrive.

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 |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • We saw evidence of sharing relevant information and care plans for patients with complex needs with the out of hours service. | |

Appropriate and safe use of medicines

The practice did not have 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) <small>NHS Business Service Authority - NHSBSA</small> | 1.36 | 0.99 | 0.94 | Variation (negative) |
| 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) <small>(NHSBSA)</small> | 7.7% | 5.4% | 8.7% | No statistical variation |

Any additional evidence or comments

The practice indicated that the number of antibacterial prescription items prescribed to the end of November 2018 was 1.107.

| 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. | Partial |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. | Partial |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | Yes |
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. | Partial |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Yes |

| Medicines management | Y/N/Partial |
|---|-------------|
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | Yes |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | NA |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Yes |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Yes |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Partial |
| 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. | Yes |
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice did not have a formal system to ensure the competence of staff employed in advanced roles. For example, audit of their clinical decision making, including non-medical prescribing were not carried out. • The practice did not stock all of the suggested emergency medicines and had not carried out a risk assessment to determine the range of medicines held. In particular the practice did not have a supply of atropine although contraceptive intrauterine devices were fitted. The practice provided evidence following the inspection that all of the suggested emergency medicines, including atropine, were in place. • We saw that the process for monitoring patients' health in relation to the use of medicines including high risk medicines prior to prescribing was not always being followed. Prescriptions for certain medicines, for example warfarin, were only issued if up to date blood results were available in the records for review by the GP. However, this was not always occurring for other medicines such as methotrexate, especially when patients had their bloods taken at the hospital. The practice was not able to evidence that the blood results had been reviewed by the GP prior to issuing the prescription. • We saw a significant event related to a repeat prescription for a controlled medicine. Two prescriptions for the same medicine had been issued within a period of 12 days. The practice had discussed the action to be taken to prevent this occurring again. The practice had amended the prescribing process so that all controlled medicines were only issued on acute prescription and the clinician must review the request. | |

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: | 9 |
| Number of events that required action: | 9 |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We saw that significant events were discussed at both the clinical and practice meetings. However, not all of the significant events that had been discussed were recorded on the significant events log. The practice sent through an updated significant log after the inspection. | |

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

| Event | Specific action taken |
|--------------------------------------|--|
| Incomplete labelling of urine sample | An incompletely labelled urine sample was sent to the laboratory. The results of the sample indicated an infection. The laboratory and the practice were unable to identify the correct patient as only the name of the patient and not the date of birth had been recorded on the bottle. The practice had introduced a proforma for reception staff to complete to ensure that all patient details were recorded on urine samples before they were sent to the laboratory. |
| Abusive patient | A new patient was verbally abusive and threatening towards staff. Staff called the police but the patient had left the building before they arrived. The practice followed correct procedures and the patient was removed from the practice list. |

| 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: | |

- We found that the practice had a system in place to demonstrate that alerts which may affect patient safety had been received, recorded and forwarded to the clinicians. However, the log did not record any details of the action taken by the practice. We discussed a recent safety alert relating to a medicine used to treat epilepsy. We looked at the records for three patients and found that one record indicated that discussions had taken place but nothing was recorded for the other two patients. The GP told us that a text message had been sent to the patient asking them to contact the practice. However, the system did not automatically save the text message in the notes. The practice provided evidence after the inspection to demonstrate that relevant patients had been contacted by text message, requesting they make an appointment with the practice pharmacist.

Effective

Rating: Good

Effective needs assessment, care and treatment

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

| | Y/N/Partial |
|--|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | Yes |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Yes |
| 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 |
| Explanation of any answers and additional evidence: | |

| 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) <small>(NHSBSA)</small> | 0.63 | 0.75 | 0.81 | No statistical variation |

Older people

Population group rating: Good

Findings

- 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.
- Patients over 75 years of age were encouraged to attend for an annual medication review with the pharmacist.
- The practice had reviewed patients prescribed hypnotics and taken action to support good prescribing practices in line with local and national guidance. Data available showed that the number of hypnotics prescribed overall by the practice was lower than the local clinical commissioning group and National averages.

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 offered Level Two and Three Diabetes Management through an any qualified provider (AQP) contract.
- Some of the practice performance on quality indicators for long term conditions was below the local and national averages. These included two quality indicators for diabetes, one for asthma and one for hypertension. The practice carried out searches to identify patients who needed to attend for reviews. The expanded nursing team provided additional resources and an increased skill set in relation to the review of patients with long term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

| 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) <small>(QOF)</small> | 72.7% | 78.7% | 78.8% | No statistical variation |
| Exception rate (number of exceptions). | 5.2% (33) | 11.3% | 13.2% | N/A |
| The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 80.6% | 81.2% | 77.7% | No statistical variation |
| Exception rate (number of exceptions). | 5.9% (38) | 6.3% | 9.8% | N/A |

| | Practice | CCG average | England average | England comparison |
|--|--------------|-------------|-----------------|--------------------------|
| The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 76.7% | 81.3% | 80.1% | No statistical variation |
| Exception rate (number of exceptions). | 8.1% (52) | 9.5% | 13.5% | N/A |

| Other long-term conditions | Practice | CCG average | England average | England comparison |
|---|--------------|-------------|-----------------|--------------------------|
| The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 72.9% | 77.3% | 76.0% | No statistical variation |
| Exception rate (number of exceptions). | 1.9% (11) | 2.5% | 7.7% | N/A |
| The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 93.8% | 91.8% | 89.7% | No statistical variation |
| Exception rate (number of exceptions). | 2.5% (9) | 8.5% | 11.5% | N/A |

| Indicator | Practice | CCG average | England average | England comparison |
|---|--------------|-------------|-----------------|--------------------------|
| The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF) | 80.0% | 84.1% | 82.6% | No statistical variation |
| Exception rate (number of exceptions). | 3.9% (66) | 2.8% | 4.2% | N/A |
| In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF) | 91.0% | 90.3% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 0.5% (1) | 4.8% | 6.7% | 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 for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice held a weekly immunisation clinic. The midwife visited the practice weekly and the health visitors held bi-monthly drop-in clinics at the health centre.
- Young people could access services for sexual health and contraception.
- The practice offered an enhanced family planning service, including contraceptive implants and Intra Uterine Coil Fitting.

| 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) | 78 | 81 | 96.3% | 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) | 50 | 51 | 98.0% | Met 95% WHO based target (significant variation positive) |
| 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) | 50 | 51 | 98.0% | Met 95% WHO based target (significant variation positive) |
| 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) | 49 | 51 | 96.1% | Met 95% WHO based target (significant variation positive) |

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.

| 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 | 70.5% | 71.8% | 71.7% | No statistical variation |

| | | | | |
|--|-------|-------|-------|--------------------------|
| 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) | | | | |
| Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE) | 72.9% | 67.9% | 70.1% | N/A |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE) | 52.7% | 49.1% | 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. (01/04/2017 to 31/03/2018) (PHE) | 73.5% | 74.8% | 70.3% | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE) | 48.4% | 44.9% | 51.9% | No statistical variation |

Any additional evidence or comments

- The practice uptake for cervical screening was 70.5%, which was below the 80% coverage target for the national screening programme. Reminder letters were sent to patients who did not attend, and discussions took place during consultations. The practice was also able to arrange screening for house bound patients.
- The practice uptake for breast and bowel cancer screening was above the national average.

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 offered patients with a learning disability an annual review. Seventy-four patients had been identified on the register and 20 had attended for an annual review during 2017/18.

**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.
- 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.
- The practice performance on the three quality indicators for patients experiencing poor mental health was in line with local and national averages.

| 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) <small>(QOF)</small> | 89.4% | 92.5% | 89.5% | No statistical variation |
| Exception rate (number of exceptions). | 2.9% (2) | 7.8% | 12.7% | N/A |
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 95.5% | 93.8% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 2.9% (2) | 4.7% | 10.5% | N/A |
| The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 82.8% | 82.6% | 83.0% | No statistical variation |
| Exception rate (number of exceptions). | 4.9% (3) | 6.0% | 6.6% | N/A |

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

| Indicator | Practice | CCG average | England average |
|---|----------|-------------|-----------------|
| Overall QOF score (out of maximum 559) | 549.6 | 531.2 | 537.5 |
| Overall QOF exception reporting (all domains) | 5.1% | 5.2% | 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. | No |

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

The practice was not able to demonstrate a programme of quality improvement. The practice was aware that a programme of quality improvement had not been implemented following the merge and there were plans to do this.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

| | Y/N/Partial |
|--|-------------|
| Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme. | Yes |
| The learning and development needs of staff were assessed. | Yes |
| The practice had a programme of learning and development. | Yes |
| Staff had protected time for learning and development. | Yes |
| There was an induction programme for new staff. | Yes |
| Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015. | Yes |
| Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation. | Yes |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | No |

| | |
|--|-----|
| 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: | |
| <ul style="list-style-type: none"> • The practice had experienced high levels of sickness and absence which had impacted on the support and management of staff. • The practice had not ensured the competence of staff employed in advanced roles by audit of their clinical decision making. | |

Coordinating care and treatment

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

| Indicator | Y/N/Partial |
|---|-------------|
| The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF) | Yes |
| We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment. | Yes |
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Yes |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Yes |
| For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services. | Yes |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • We saw evidence of sharing relevant information and care plans for patients with complex needs with the out of hours service. | |

Helping patients to live healthier lives

Staff were 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 |
| Explanation of any answers and additional evidence: | |

| Smoking Indicator | Practice | CCG average | England average | England comparison |
|---|-------------|-------------|-----------------|--------------------------|
| The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 97.3% | 97.1% | 95.1% | No statistical variation |
| Exception rate (number of exceptions). | 0.3% (9) | 0.3% | 0.8% | N/A |

Consent to care and treatment

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

| | Y/N/Partial |
|--|-------------|
| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | Yes |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | Yes |
| The practice monitored the process for seeking consent appropriately. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff we met had a clear understanding and awareness of capacity, best interest decisions and of Gillick competencies. | |

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 |
| Explanation of any answers and additional evidence: | |

| CQC comments cards | |
|--|----|
| Total comments cards received. | 39 |
| Number of CQC comments received which were positive about the service. | 38 |
| Number of comments cards received which were mixed about the service. | 1 |
| Number of CQC comments received which were negative about the service. | 0 |

| Source | Feedback |
|--------------------------------|--|
| Interviews with patients | We spoke with one patient during the inspection. They told us that staff treated them with kindness and respect. |
| CQC comment cards | Thirty-nine comment cards were completed by patients. All of the comment cards contained positive comments about the caring service provided. Staff were described as caring, kind and respectful. |
| Healthwatch Walsall | Healthwatch Walsall had received positive comments from three patients. One patient made reference to the support and time that the practice had given to a patient when discussing a potential diagnosis. |
| NHS Choices All Saints Surgery | Three comments had been posted on NHS Choices since November 2017. The practice had not responded to these comments. Two patients rated their experience as two star and one rated their experience as one star. Two of the patients commented that some of the GPs were unhelpful and didn't listen to the patient during consultations. However, one of these patients spoke positively about their experience with one of the GPs and commented they always tried to book with that GP. |
| NHS Choices Field Road Surgery | Three comments had been posted on NHS Choices since August 2017. The practice had responded to both positive and negative comments. All three patients |

| | |
|---|---|
| | rated their experience as one star. Patient comments related to the attitude of both reception staff and certain GPs. |
| Summary of Friends and Family Test 24/04/2018 to 21/01/2019 | The practice had received 505 completed forms during this period. Of these, 90% of respondents would recommend the practice, 7% of respondents would not recommend the practice and 3% of respondents answered neither or did not know. |

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 changed in 2018.

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 8988 | 264 | 112 | 42.4% | 1.25% |

| 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) | 89.2% | 87.0% | 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) | 87.5% | 85.8% | 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) | 97.7% | 95.3% | 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) | 93.4% | 81.8% | 83.8% | No statistical variation |

Any additional evidence or comments

The practice had reviewed the National GP survey results from 2018 for both practices and identified that patients were satisfied with the approach of the healthcare professionals and the consultations.

Question

Y/N

The practice carries out its own patient survey/patient feedback exercises.

Yes

Any additional evidence

The representative of the PPG told us they had supported the practice with surveys in the past. They told us the practice had discussed carrying out a survey following the merger, although this had not been undertaken.

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 |
| Explanation of any answers and additional evidence: | |

| Source | Feedback |
|---------------------------|---|
| Interviews with patients. | We spoke with one patient during the inspection. They told us they had been referred to an education course on the management of their relative's long term condition. |
| CQC Comment Cards | Thirty-nine comment cards were completed by patients. Positive comments included that they were always listened to, staff were thorough during consultations, staff explained in detail the problems that patients attend with. Two of the GPs were mentioned specifically as being attentive and listening to the reasons for attending. |
| Healthwatch Walsall | Healthwatch Walsall had received positive comments from three patients. They commented that they did not feel rushed during appointments, that the GPs listened to them, gave them time to ask questions, provided answers and advice, resulting in them feeling supported. |

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) | 94.7% | 91.6% | 93.5% | No statistical variation |

Any additional evidence or comments

The practice had reviewed the National GP survey results from 2018 for both practices and identified that patients were satisfied with the support and management of their long term conditions.

| | 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 |
| Explanation of any answers and additional evidence: | |

| Carers | Narrative |
|--|--|
| Percentage and number of carers identified. | The practice population on the day of the inspection was 8,988. The practice had 128 registered carers. This represented 1.4% of the practice population. |
| How the practice supported carers. | The practice maintained a register of carers and had developed a carers pack. The practice had also developed a carers corner in the reception area, which contained useful information and advice. Carers were offered an annual flu vaccination. |
| How the practice supported recently bereaved patients. | The practice sent a condolence card to the family. Patients were signposted to bereavement services as required. |

Privacy and dignity

The practice respected 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 |
| Explanation of any answers and additional evidence: The patient seating area was located away from the reception desks. | |

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 |
| Explanation of any answers and additional evidence: | |

| Practice Opening Times | |
|---|------------------|
| Day | Time |
| Opening times: | |
| Monday | 7.30am to 6.30pm |
| Tuesday | 7.30am to 6.30pm |
| Wednesday | 7.30am to 6.30pm |
| Thursday | 7.30am to 6.30pm |
| Friday | 7.30am to 6.30pm |
| Number of GP Appointments available: | |
| Monday | 92 |
| Tuesday | 90 |
| Wednesday | 89 |
| Thursday | 90 |
| Friday | 75 |
| Number of Advanced Nurse Practitioner Appointments available: | |
| Monday | 75 |
| Tuesday | 67 |
| Wednesday | 67 |
| Thursday | 67 |
| Friday | 45 |
| Number of Practice Nurse Appointments available: | |
| Monday | 54 |
| Tuesday | 90 |

| | |
|--|-----|
| Wednesday | 84 |
| Thursday | 90 |
| Friday | 44 |
| Number of Health Care Assistants Appointments available: | |
| Monday | 131 |
| Tuesday | 122 |
| Wednesday | 122 |
| Thursday | 122 |
| Friday | 47 |
| Number of Advanced Clinical Pharmacist Appointments available: | |
| Monday | 22 |
| Tuesday | 22 |
| Wednesday | 30 |
| Thursday | 31 |
| Friday | 22 |

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.

Extra GP appointments were available between:

- 6.30pm – 9pm weekdays (all four hubs)
- 10am – 3pm weekends (excluding Darlaston Health Centre & Portland Medical Practice)
- 11am – 1.30pm Bank Holidays (all four hubs)

Appointments could be booked by calling 01922 501999 during the following times:

- 8am – 9pm weekdays
- 10am – 3pm weekends
- 11am – 1.30pm bank holidays

NHS 111 were also able to book appointments for patients.

National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 8988 | 264 | 112 | 42.4% | 1.25% |

| 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) | 97.6% | 94.4% | 94.8% | No statistical variation |

Any additional evidence or comments

Older people

Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- Patients over the age of 75 years were offered a same day appointment if required.
- 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.

People with long-term conditions

Population group rating: Good

Findings

- The practice liaised with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues as required.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.
- The practice provided in-house electrocardiogram (ECG) which is a simple test that can be used to check the heart's rhythm and electrical activity.
- The practice provided in house Spirometry. (Spirometry is a simple test used to help diagnose and monitor certain lung conditions).
- The practice offered insulin initiation for patients who needed to commence insulin therapy.

Families, children and young people

Population group rating: **Good**

Findings

- Appointments were available from 7.30am Monday to Friday with either a GP, practice nurse or health care assistant.
- 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.
- All parents or guardians calling with concerns about a child under the age of 5 years 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. For example, early morning appointments, telephone consultations and access to the extended hours hub for evening and weekend appointments.
- The practice was open from 7.30am five days a week. Pre-bookable appointments were also available to all patients at additional locations within the area, through the Extended GP Access Service. Appointments were available between 6.30pm and 9pm on weekdays, between 10am and 3pm on Saturday and Sunday, and 11am and 1.30pm on bank holidays.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including 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

- 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. This included promoting counselling through the Talking Therapies Service.

Timely access to the service

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

National GP Survey results

| | 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 |
| Explanation of any answers and additional evidence: | |

| 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) | 85.4% | 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) | 73.7% | 67.3% | 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) | 73.2% | 65.0% | 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) | 73.1% | 71.2% | 74.4% | No statistical variation |

Any additional evidence or comments

The practice had reviewed the National GP survey results from 2018 for both practices and identified that patients were less satisfied with the booking appointment process and reception at Field Road Surgery than at All Saints Surgery. The practice had investigated the reasons for this and implemented changes to address the issues. The changes included the availability of an additional member of staff during busy periods to assist front line reception staff with phone calls, queries and bookings; this member of staff responded to queries about investigation results and asked the local pharmacies to collect prescriptions either at lunch time or early afternoon.

The practice also identified that patients were less satisfied with the choice of appointment they were offered. To address this, reception staff had been instructed to offer patients an appointment with either a male or female GP, health care assistant, advanced nurse practitioner or a senior pharmacist.

| Source | Feedback |
|--|--|
| Interviews with patients | We spoke with one patient during the inspection. They told us they could get an appointment when they needed one. |
| CQC Comment Cards | Thirty-nine comment cards were completed by patients. Nine comment cards made reference to appointments. Seven patients commented that they were able to get appointments, one patient commented that sometimes they had to wait for an appointment and one patient commented that being able to get an appointment was getting better. |
| NHS Choices All Saints Surgery Post Merger | Three comments had been posted on NHS Choices since November 2017. The practice had not responded to these comments. Two patients rated their experience as two star and one rated their experience as one star. One comment posted in May 2018 indicated that the patient had waited 12 days for routine appointment. They commented that when they visited the practice the waiting room was empty and the GP appeared to be waiting for patients to arrive. |
| NHS Choices Field Road Surgery Post Merger | Three comments had been posted on NHS Choices since August 2017. The practice had responded to both positive and negative comments. All three patients rated their experience as one star. One comment posted in December 2018 commented on the difficulty the patient experienced when trying to make a routine appointment. |
| Healthwatch Walsall | Healthwatch Walsall had received two comments relating to appointments, one of which was positive and the other negative. |

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. | 2 |
| 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. | 0 |

| | Y/N/Partial |
|---|-------------|
| Information about how to complain was readily available. | Yes |
| There was evidence that complaints were used to drive continuous improvement. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Information about how to make a complaint was displayed in the waiting area and on the website. Complaints leaflets and forms were readily available. The practice manager told us that she will deal with verbal complaints as they arise. However, these are not recorded so it is not possible to review these for any trends or identify lessons to be learnt. | |

Example of learning from complaints.

| Complaint | Specific action taken |
|--|--|
| A relative was unhappy with the access to home visits. | The relative of a patient contacted the practice to request a home visit and was advised by the reception staff to call an ambulance due to the nature of the medical condition described. The relative felt that reception staff were refusing a home visit. On investigation it was found that reception staff had acted appropriately in the circumstances and given correct instructions to the relative. The reception staff followed the home visiting policy in place at the time of the incident. As a consequence of this complaint the visiting policy and has been reviewed and amended to ensure that it clearly sets out the procedure to follow. |

Well-led

Rating: Requires improvement

Leadership capacity and capability

We rated the practice as requires improvement for being well-led because:

- There had been a lack of strategic oversight and planning to bring about the creation of the new organisation. There was little evidence to support that following the merger the practice operated as one organisation.
- The leaders had not ensured that the Care Quality Commission had been notified of the changes to registration following the merger. The registration had not been amended to reflect the change in partners, the registered manager and additional regulated activities.
- The practice did not have a clear and effective process for managing risks, issues and performance.

Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

| | Y/N/Partial |
|---|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Partial |
| They had identified the actions necessary to address these challenges. | No |
| Staff reported that leaders were visible and approachable. | Partial |
| There was a leadership development programme, including a succession plan. | No |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">• In April 2018 All Saints Surgery and Field Road Surgery merged. The two practices were located in two separate wings of the same building. They continue to operate out of these separate areas, have retained the original names over the reception desks and the majority of staff continue to work from their original site. The practice has continued to operate two telephone numbers and two websites. The majority of patients have continued to access services from the practice they used pre April 2018.• There was some evidence of the two staff teams coming together through staffing meetings and shared policies and procedures.• The practice had not submitted a notification or an application for the required changes to its registration with the Care Quality Commission to be made. This included: registration of the additional partner, the change of registered manager and the registration of additional regulated activities.• Th practice notified us following the inspection that they were no longer provide any family planning activities until the registration had been updated.• The lead GPs had interests and roles outside of the practice which impacted on their availability during the working week. | |

Vision and strategy

The practice had a clear vision but it was not supported by a 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. | Partial |
| There was a realistic strategy to achieve their priorities. | No |
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | No |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Partial |
| Progress against delivery of the strategy was monitored. | No |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice had developed a business plan for 2018 to 2022, which included the merger process. This had not been developed into a strategy that clearly detailed its vision and values and how the priorities would be achieved and monitored. | |

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 |
| Explanation of any answers and additional evidence: | |

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

| Source | Feedback |
|-----------------------|---|
| Interviews with staff | <p>Staff told us that they felt part of one team and valued the weekly meetings as a means of communication and getting to know each other.</p> <p>Members of the nursing team commented that they valued being part of the team and the support that they were able to provide for each other. They told us that they were working towards aligning working practices within the staff team.</p> |

Governance arrangements

The overall governance arrangements were not always ineffective.

| | Y/N/Partial |
|---|-------------|
| There were governance structures and systems which were regularly reviewed. | Partial |
| Staff were clear about their roles and responsibilities. | Yes |
| There were appropriate governance arrangements with third parties. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had a four weekly meeting plan, which included a clinical meeting, practice meeting, team debrief and an informal meeting. The clinical and practice meetings were minuted and included discussions on significant events, complaints and safety alerts. • Communication was effective and organised through structured, minuted meetings. • The GPs had lead managerial and clinical roles within the practice. • There was no evidence to support that governance structures and systems had been reviewed since the merger to ensure they were working effectively. | |

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

| | Y/N/Partial |
|---|-------------|
| There were comprehensive assurance systems which were regularly reviewed and improved. | Partial |
| There were processes to manage performance. | Partial |
| There was a systematic programme of clinical and internal audit. | No |
| There were effective arrangements for identifying, managing and mitigating risks. | Partial |
| A major incident plan was in place. | Yes |
| Staff were trained in preparation for major incidents. | Yes |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | No |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • The practice did not have a programme of clinical and internal review. • The practice had continued to provide a regulated activity that they were not registered for and had not considered the risk of not stocking an emergency medicine considered to be required when carrying out this regulated activity. • The practice did not review the performance of staff working in advanced clinical roles. | |

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

| | Y/N/Partial |
|---|-------------|
| Staff used data to adjust and improve performance. | Partial |
| Performance information was used to hold staff and management to account. | Partial |
| Our inspection indicated that information was accurate, valid, reliable and timely. | No |
| Staff whose responsibilities included making statutory notifications understood what this entails. | No |
| Explanation of any answers and additional evidence: | |
| <ul style="list-style-type: none"> • The practice had not notified the Care Quality Commission (CQC) of the change in registered manager or that additional partners had joined the partnership. • We saw that the policies and procedures had been amended and were in the name of Pinfold Medical. The practice submitted a notification to CQC indicating that the practice was also known as Pinfold Medical dated 15 January 2019. • We saw no evidence in the building that the practice was known as Pinfold Medical. The signage at the reception desks still referred to the original names of the two practices. | |

Engagement with patients, the public, staff and external partners

The practice tried to involve 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. | Partial |
| Staff views were reflected in the planning and delivery of services. | Partial |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Yes |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had reviewed and acted upon the GP survey results for both practices. The practice also listened to feedback received by patient participation group members. However, the practice had not undertaken a patient survey following the merger. • The practice had not formally sought the views of staff on the planning and delivery of services following the merger to see if any changes or improvements could be made. • The practice had worked closely with the clinical commissioning group to facilitate the merger of the two practice. | |

Feedback from Patient Participation Group.

| Feedback |
|---|
| We met with a member of the patient participation group (PPG). They told us that the members of both PPGs had come together following the merger. The PPG met with the practice four times a year and provided feedback to the practice from patients. They told us they had also spent time in the reception area supporting the practice to encourage patients to sign up for online services. They told us they had previously supported with patient surveys but these had been put on hold due to the merger. They also told that PPG members had not received any negative feedback regarding the merger. |

Continuous improvement and innovation

There was little 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. | No |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • One of the GP partners was a member of the local Clinical Commissioning Group governing body. • Although significant events were discussed and recorded on the log, the information was not always up to date or shared in a timely manner. • Verbal complaints were not recorded so trends and lessons to be learnt could not be identified. • The practice did not have a programme of clinical and internal review. | |

Examples of continuous learning and improvement

- The practice was a training practice for GP registrars and medical students. The practice also provided placements for student nurses.
- Clinicians were encouraged to attend training and educational sessions provided within the locality.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

| | Variation Band | Z-score threshold |
|---|----------------------------------|-------------------|
| 1 | Significant variation (positive) | $Z \leq -3$ |
| 2 | Variation (positive) | $-3 < Z \leq -2$ |
| 3 | No statistical variation | $-2 < Z < 2$ |
| 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.
- 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.