

# Care Quality Commission

## Inspection Evidence Table

### OHP-Poolway Medical Centre (1-4335420807)

Inspection date: 15 January 2019

Date of data download: 11 January 2019

## Overall rating: Requires Improvement

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

### Safe

### Rating: Requires Improvement

The service was rated as requires improvement for safe services as risks were not always effectively considered and mitigated against. Prescription pads were not kept fully secured and the management of prescription pads was not effective as there was no auditable process to prevent misuse.

#### Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse. However, in some areas they needed further improvement.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Y
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).	Y
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y

Safeguarding	Y/N/Partial
<p>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.</p>	Y
<p>Policies were available on the shared drive and we could access these on the day. However, not all staff we spoke with were aware how to access them.</p> <p>We saw that many of the policies in place were being updated or under review. The practice had access to a range of policies through their provider organisation (OHP) but were not currently utilising them. The practice manager told us that they were reviewing all their policies and would be adopting some of the provider's policies where it was more relevant. However, this was an ongoing process.</p> <p>Following the inspection, the practice further informed us that upon being provided with a new policy, a process of consultation with key staff members (doctors, nurses and administration staff) is followed to determine whether they need to carry out any changes to a policy before they can formally be adopted. All views are taken into account and a new draft version is produced and discussed by key members of staff to produce any further feedback. Once the changes are agreed upon, then the policy is formally adopted and circulated to all members of staff.</p> <p>We were told that most of the staff members were on extended leave throughout December 2018 (due to the Christmas holidays) and so some of these policies had not been consulted upon, and thus not formally adopted.</p> <p>Furthermore, the practice had a meeting with senior members of the provider (OHP) in March 2019 and agreed for the provider to assist in transferring all policies on to GP TeamNet. This would simplify the process of reviewing and updating policies.</p> <p>Following the inspection, the practice informed us that due to remote updating of the IT system by an engineer caused the shortcut to the policy to be moved to a separate folder. Staff were therefore, unable to locate the policy on the day.</p> <p>Furthermore, following a meeting in March 2019 with the provider (OHP) the practice had decided to transfer all their policies to GP TeamNet which can be accessed by all staff members using a login password.</p> <p>We saw there was a DBS check for the practice nurse. This was from their previous employer and was carried out within the last three months. The practice had decided not to undertake any further DBS checks and had supported this decision with a risk assessed.</p> <p>Reception staff had not undergone a DBS check. However, staff members told us that they did not carry out the role of a chaperone and the practice decided not to carry out DBS checks for these staff.</p>	

Recruitment systems	Y/N/Partial
<p>Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).</p>	Y
<p>Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.</p>	Y

There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff had any necessary medical indemnity insurance.	Y
Explanation of any answers and additional evidence:	
<p>We reviewed staff recruitment files and found gaps in the recruitment checks of one clinical member of staff who had started within the last 24 months. At the time of inspection, we found there was no evidence that references had been obtained; that signed contracts, confidentiality agreements or current DBS checks were in place; or evidence of interview and staff induction for this member of staff. Following the inspection, the practice forwarded to us references, signed contracts and signed confidentiality statements for this member of staff. At our previous inspection in November 2017 we also identified issues in relation to gaps in relation to recruitment checks, the practice manager assured us at the time that they had this information but were unable to locate it due to a recent move.</p> <p>The practice was unable to provide assurance in relation to staff immunisation status on the day of inspection for relevant staff. Following the inspection these were forwarded to us.</p> <p>Following the inspection, the practice stated that they were unable to produce all relevant documentation related to recruitment on the day of the inspection. Some documentation was in recruitment files whilst others were with the GP partner (who at the time of review was on home visits) and the practice manager. The practice sent the remaining documentation to the CQC following the inspection.</p>	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: January 2019	Y
There was a record of equipment calibration. Date of last calibration: October 2018	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: August 2017	Y
There was a log of fire drills. Date of last drill: 22/2/18	Y
There was a record of fire alarm checks. Date of last check: 10/01/2019 (weekly test)	Y
There was a record of fire training for staff. Date of last training: Blue stream (various dates)	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: June 2018	Y

Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	

<b>Health and safety</b>	<b>Y/N/Partial</b>
Premises/security risk assessment had been carried out. Date of last assessment: November 2018	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: November 2018	Y
Explanation of any answers and additional evidence:  The practice was unable to provide a health and safety risk assessment on the day. Following the inspection, we were provided with risk assessments.	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit: 24/12/2018 (99%)	Y
The practice had acted on any issues identified in infection prevention and control audits.	N/A
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	

## Risks to patients

### There were gaps in systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	N
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
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.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
There was one permanent GP at the practice, who was a partner of OHP, they told us that there was another GP partner at the practice however they had been on leave and had not worked at OHP-Poolway Medical Centre for a significant length of time. There was no clear return date for this partner. We saw evidence that the provider organisation had tried to engage with the practice to identify and offer support	

required but this had not been taken up. The GP told us that they did not take annual leave and the practice was reliant on locum staff. The GP carried out many tasks without support that if they were absent would potentially create significant challenges in the running of the practice.

Some patient appointments were dependent on tasks undertaken by the practice manager and could not be booked in their absence. There was no contingency plan in place should they become absent from the practice. Following the inspection, the practice informed us that contingency plans were in place if the practice was away.

We were told that the GP partner would cover any unplanned absences from locum GPs and the practice manager would cover reception staff for unplanned absences. There was no plan in place to cover the unplanned leave for the GP or Practice Manager.

Following the inspection, the practice informed us that they had a meeting with the provider (OHP) in March 2019 and agreed to join the CCG's Virtual Desktop Infrastructure Programme (VDI) platform. This would allow some authorised personnel from OHP to remotely log on to their clinical system from any location in the event of an emergency/ absence to provide assistance.

The provider (OHP) central team were working to develop resilience within the workforce so that they could better support member practices and help improve work-life balance. This included an internal locum pool managed through an external locum agency. Both clinical and non-clinical staff who worked at an OHP member practice could join the scheme and offer their availability to support and work in other practices and practices could put out requests for staff when needed. There were currently 35 members of staff who had signed up to working in this pool. The practice told us that they had not accessed this service.

On the day of the inspection the practice was unable to provide evidence of induction for locum GPs on the day of the inspection. Following the inspection this was sent to us.

The landlord was undertaking building work on part of the premises and we did not see evidence of any assessments to identify any possible risks to patients.

## 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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
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.	Y
Explanation of any answers and additional evidence:	

## 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>	1.22	0.90	0.94	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) <small>(NHSBSA)</small>	7.3%	7.6%	8.7%	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	N
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
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.	Y
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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
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	N/A



Medicines management	Y/N/Partial
and disposal of these medicines, which were in line with national guidance.	
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
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.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>On the day of inspection, we found prescription stationery was not fully secured. However, it was located in an area accessible to authorised persons only.</p> <p>Systems for monitoring prescription stationery were not fully effective in that they did not take account of total stock should any go missing.</p> <p>We also saw written prescription pads used for home visits. We saw one prescription pad used for home visit was kept in the cabinet with a log of entries. Records we looked at showed four prescriptions had been used since 2016. We spoke with a reception staff member to ask if this was correct, they told us that the GP may have another prescription pad for home visits. However, this had not been accounted for.</p> <p>Following the inspection, the practice stated that the current home visit prescription pad was kept locked in the store room in a locked cabinet. The store room had restricted access to key personnel only and was managed by the GP and the practice manager. Reception staff were not aware of this arrangement for storage home visit prescription pads at the time of the inspection.</p> <p>The practice was aware of its antimicrobial prescribing and where improvements were required. The practice was working with the CCG pharmacists to improve prescribing of some antibiotics. The practice shared with us data which demonstrated that improvements were being achieved although further improvements were required in some areas.</p>	

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

The practice learned and made improvements when things went wrong. However, all significant events had been of a clinical nature, while none were non-clinical or related to administrative issues

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	8
Number of events that required action:	8
Explanation of any answers and additional evidence:	
<p>We were not assured that the incident reporting process was fully embedded across the practice team. The practice had a policy and process for recording significant events. Minutes of meetings demonstrated that learning of significant events were shared with staff locally. However, not all staff we spoke with were aware of any incidents. We saw that all significant events had been of a clinical nature, while none were non-clinical or related to administrative issues.</p> <p>The practice was required to report significant events to the central OHP team as part of quality monitoring. However, none had been submitted between May and October 2018.</p>	

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

Event	Specific action taken
Aggressive patient	The GP was concerned regarding a patient who was aggressive during consultation. They were on the mental health register and the GP followed up with other agencies to ensure the patient was seeking help with their mental health issues. They also ensured any children living with the patients were not subject to any safeguarding concerns.
Concerns whilst on home visit	The GP witnessed concerns whilst on a home visit with a patient's relative and raised a safeguarding alert. Currently this was ongoing.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We were told that the practice had registered to receive safety alerts including MHRA alerts. Alerts were also received through GP TeamNet (a web-based sharing and compliance platform for GP practices). Alerts were reviewed by the GP, actioned and filed. We looked at several examples such as that related Valproate (October 2018) and saw that they had been appropriately actioned.</p>	

## Effective

**Rating: Good**

### Effective needs assessment, care and treatment

**Patients' needs were not 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.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways were in place to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
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) (NHSBSA)	1.31	0.81	0.81	No statistical variation

## Older people

**Population group rating: Good**

### Findings

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

## 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.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. The practice had one of the lowest emergency COPD admission rate to secondary care despite having twice the prevalence. The practice provided rescue packs for patients to manage exacerbation of their condition and to reduce secondary admission.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring. The practice had purchased blood pressure monitoring for patients to use. The practice offered home blood pressure monitoring for patients.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- We identified one area in which the practice was an outlier, this related to the percentage of patients with diabetes whose last blood pressure reading was 140/80 or less. The practice achieved 60% compared to the CCG average of 77% and the national average of 78%. The GP told us that they had been working to improve this indicator and had achieved 71% since April 2018.

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>	85.4%	80.0%	78.8%	No statistical variation
Exception rate (number of exceptions).	15.2% (27)	12.4%	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>	59.9%	77.1%	77.7%	Variation (negative)
Exception rate (number of exceptions).	9.0% (16)	10.4%	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>	85.2%	81.2%	80.1%	No statistical variation
Exception rate (number of exceptions).	9.0% (16)	11.6%	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>	75.3%	76.7%	76.0%	No statistical variation
Exception rate (number of exceptions).	3.1% (5)	6.2%	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>	90.2%	91.3%	89.7%	No statistical variation
Exception rate (number of exceptions).	0.9% (1)	11.2%	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)	81.4%	83.0%	82.6%	No statistical variation
Exception rate (number of exceptions).	3.6% (13)	4.5%	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)	89.5%	88.8%	90.0%	No statistical variation
Exception rate (number of exceptions).	2.6% (1)	8.1%	6.7%	N/A

#### Any additional evidence or comments

QOF data showed that the percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 140/80 mmHg or less was 59% compared to the local CCG and national average of 77%. We spoke with the GP on the day and they told us that they were aware of this. They told us that part of this was due to patients missing their appointments but had been working to engage these patients further. We were told that they had achieved 71% since April 2018 so and they felt that they would reach the target of 78% by the end of the QOF year.

#### 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 uptake rate for one year old was above the local and national average.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Young people could access services for sexual health and contraception.
- Same day appointments were available for children.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO
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				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) <small>(NHS England)</small>	30	31	96.8%	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) <small>(NHS England)</small>	29	31	93.5%	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) <small>(NHS England)</small>	28	31	90.3%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) <small>(NHS England)</small>	28	31	90.3%	Met 90% minimum (no variation)

### Any additional evidence or comments

The data above shows that the practice had achieved 97% completion for a range of immunisation for children aged one, which was above the local and national average. The GP told us that they ensured reception staff engaged with relevant patients and their family. The GP also carried out all the first vaccinations and some of this was also done opportunistically.

### Working age people (including those recently retired and students)

### Population group rating: Requires improvement

#### Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- The practice's uptake for cervical screening was in line with local and national averages. However, the practice told us that they were working with hard to reach patients to improve this further.
- Uptake of other national cancer screening programmes such as breast and bowel screening was below local and national averages.
- 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.



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Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	71.8%	68.1%	71.7%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	59.6%	64.0%	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)	39.0%	44.1%	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)	100.0%	73.8%	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)	58.3%	52.2%	51.9%	No statistical variation

**People whose circumstances make them vulnerable**

**Population group rating: Good**

Findings
<ul style="list-style-type: none"> <li>• End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.</li> <li>• The practice held a register of patients living in vulnerable circumstances including those with a learning disability.</li> <li>• The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.</li> <li>• The practice demonstrated that they had a system to identify people who misused substances.</li> <li>• The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia.</li> <li>• The practice reviewed young patients at local residential homes.</li> </ul>

**People experiencing poor mental health  
(including people with dementia)**

**Population group rating: Good**

**Findings**

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.

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>	95.0%	93.2%	89.5%	No statistical variation
Exception rate (number of exceptions).	4.8% (1)	9.5%	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>	95.0%	93.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	4.8% (1)	7.8%	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>	95.5%	85.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	0 (0)	6.0%	6.6%	N/A

### Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	543.4	546.1	537.5
Overall QOF exception reporting (all domains)	5.5%	6.1%	5.8%

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

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

- The service had carried out audits to demonstrate quality improvement. We looked at an audit on Urinary Tract Infections (UTIs) and the second cycle demonstrated quality improvement.
- Another audit on high risk medicines where patients had an increased risk of sepsis. Following the audit relevant patients were sent a leaflet on sepsis and the relevant actions to take.

## Effective staffing

**Staff were up to date with training but were not always able to demonstrate some skills, knowledge and experience such as accessing practice policies.**

	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.	Y
The learning and development needs of staff were assessed.	Partial
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Partial
There was an induction programme for new staff.	Partial
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	
<p>The practice had an online system to ensure staff were up to date with their training such as infection control, information governance, safeguarding as well as other training. However, the reception staff we spoke with were not always aware of some systems and processes in the practice. For example, they were unable to tell us how they would access policies or tell us about certain policies. We asked reception staff if there was a hearing loop in the building and they told us that they were unaware of this even though these staff had worked at the practice for several years. The practice manager showed us the location of the loop which was in the reception room.</p> <p>Although we saw evidence of appraisals the practice did not have an effective system for ensuring staff were given regular opportunities to discuss their learning needs or any concerns. During the inspection we saw that the last appraisal for reception staff had been carried out in October 2017 and was overdue. The practice manager told us that they had carried out an appraisal recently and documentation was with the staff member for completion. Reception staff members we spoke with confirmed appraisals had been carried out the previous day. The practice forwarded these following the inspection and showed that they had been carried out on 14 January 2019. At our previous inspection in November 2017 we also found that appraisals had been carried out a few days prior to inspection.</p>	

## Coordinating care and treatment

**Staff worked together and with other organisations to deliver effective care and**

**treatment.**

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
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.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Minutes of meeting we saw confirmed that regular multidisciplinary meetings took place.</p>	

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence:	
The service referred patients to other services such as the befriending service, counselling, transport services as well as other social prescribing organisations. We saw examples where the GP had received positive feedback following a patient referral to an organisation.	

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>	97.0%	96.1%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.2% (1)	0.6%	0.8%	N/A

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Explanation of any answers and additional evidence:  There was a process to document patients consent if they underwent a procedure.	



# Caring

## Rating: Good

### Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
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.	36
Number of comments cards received which were mixed about the service.	3 (access)
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Patient interview	We spoke with two patients and received positive feedback about the GPs.
Comment cards	We received positive feedback regarding staff and the GPs. Patients told us that all medical problems were dealt by the practice appropriately.

## 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
2190	405	91	22.5%	4.16%

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)	89.7%	87.7%	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)	90.2%	85.9%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	95.1%	95.4%	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)	76.1%	81.0%	83.8%	No statistical variation

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

Any additional evidence
<p>The practice told us that they had carried out an in-house patient survey in December 2018 but were unable to produce any evidence of this. We were told that the results had yet to be analysed and therefore were unable to produce any information about this survey. Not all staff who worked at the practice were aware that an inhouse patient survey had been undertaken.</p> <p>National GP patient surveys results were in line with the national average for questions about consultations with the GPs and other health care professionals.</p>

### 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.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence:	

Source	Feedback
Interviews with patients.	We spoke with two patients on the day. Patients were positive about the service they had received. We were told that staff were caring, professional and respectful.
NHS Choices	There was mixed feedback regarding patient involvement in decisions about their care and treatment. Some patients were positive about the GP and administration. Patients stated that these staff were always polite and helpful. Other comments stated that some staff were not always polite when speaking to them on the telephone.

### National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP	95.2%	92.8%	93.5%	No statistical

Indicator	Practice	CCG average	England average	England comparison
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)				variation

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

Carers	Narrative
Percentage and number of carers identified.	The practice manager carried out a search on the system which showed that they had registered 11% of their patient as carers. We were unsure of the criteria used during the search.
How the practice supported carers.	We were told that the practice offered flu vaccination and health checks to carers. However, the practice was unable provide evidence on the day to demonstrate the number of patients that had been invited and the number that had undertaken a health check or received a flu vaccination.
How the practice supported recently bereaved patients.	The service sent out letters with contact details of support agencies so that patients were able to access any further help where relevant. The GP also called the spouse of the deceased to ensure they were supported.

## 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.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:	

## Responsive

## Rating: Requires Improvement

We rated the service as requires improvement for responsive services as patient feedback from the national GP survey showed experience of making an appointment and satisfaction with appointment times were significantly below local and national averages.

### Responding to and meeting people's needs

#### Services did not meet patients' needs.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
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.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y
Explanation of any answers and additional evidence:	

Practice Opening Times	
Day	Time
Opening times: As stated on the practice leaflet and website.	
Monday	08.15 – 18.30
Tuesday	08.15 – 18.30
Wednesday	08.15 – 13.00
Thursday	08.15 – 18.30
Friday	08.15 – 18.30
Appointments available:	
Monday	09.00 – 12.00 14.00 – 16.00
Tuesday	09.00 – 12.00 15.00 – 18.30
Wednesday	09.00 – 12.00
Thursday	09.00 – 12.00 15.00 – 18.30
Friday	09.00 – 12.00 Ad-hoc
At our previous inspection in November 2017 we rated the practice requires improvements for providing responsive services as patients did not always find it easy to access care when they needed it. At the time the practice had recently introduced a new telephone system which enabled them to monitor incoming calls. They also spoke about the return of one of the GPs and employing additional reception staff to help improve access however, this had not happened. At this inspection we found access continued to be an issue.	

The building closed at 13.00 – 14.00 and the phone lines were diverted to the practice manager who took calls from patients. The practice manager would book appointments for patients if necessary.

The practice was closed on Wednesday afternoons for appointments but we were told that plans were to open.

The practice told us that although appointment times were from 14.00 to 16.00, the lead GP would always be in the building and if required or urgent, patients would be seen. The practice also operated an ad-hoc appointment system on Fridays where patients could be seen.

Following the inspection, the practice informed us that on Wednesdays a telephone triage clinic was available from 15.00 to 17.30 (emergency patients could also be booked into this surgery). However, the practice website had yet to be updated as it stated that it closed at 13.00. We were also told that every fortnight there was a special clinic run from 15.00 to 18.30 by the GP partner which included baby clinic (8-week postnatal checks for mothers and 8 weeks baby checks for babies) and extended appointments for patients on a care plan/or on the Mental Health or Learning Disability Register.

Pre-bookable appointments were available only one or two days in advance. During the inspection we saw that where reception staff were unable to find an appointment for a patient they were put on a list for the practice manager to call back. We witnessed patient calls being made and patients being asked the reason for their call. We saw no protocols in place to determine how these patients needing appointments were being managed or prioritised, this was sent to us following the inspection.

The practice manager explained that when they took calls from patients, if the patient said they needed to be seen urgently they were booked on the system or the GP called back to triage before seeing them. The practice manager also stated that if patients wanted to see the GP outside consulting times for non-clinical issues such as sick notes the practice manager would advise that they book during normal appointment times. Whilst we were told that only the GP was triaging calls there was a lack of clear protocols available to all staff.

The practice had a telephone system that allowed staff to identify those patients that called the surgery but were not able to get through. The system also enabled the service to identify the number of times a patient had called the surgery. The practice manager told us that they always ensured that those patients that called but were unable to get through were called back to ensure their needs were being met. However, there was no clear protocols in place for managing these calls in a consistent way.

## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
2190	405	91	22.5%	4.16%

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)	95.3%	94.5%	94.8%	No statistical variation

### Older people

### Population group rating: Requires Improvement

#### Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice participated in the ambulance triage scheme in which GPs provide advice to paramedics and facilitate support for patients with primary care as an alternative to accident and emergency.
- The practice participated in the 'Healthy Friends' project supported by Age UK to help the elderly with disease management and reduce social isolation.
- The practice had a hearing loop but reception staff were unaware of this.

### People with long-term conditions

### Population group rating: Requires Improvement

#### Findings

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



- The practice worked with specialist consultants and nurses from the local hospital to support the more complex patients with diabetes and chronic obstructive pulmonary disease through the use of virtual clinics.
- The practice offered insulin initiation which enabled patients to be seen closer to their home rather than in secondary care.

## Families, children and young people

## Population group rating: Requires Improvement

### Findings

- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary. GP appointments finished at 4pm however practice staff told us that they would speak to the principal GP who was usually on site.
- The nurse worked on Mondays and Thursdays from 9am to 6pm. School children could attend without the need to miss school on these days.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- The practice offered various clinics for this population group including antenatal, postnatal and baby clinics.
- Baby changing facilities were available in the premises.

## Working age people (including those recently retired and students)

## Population group rating: Requires Improvement

### Findings

- Patients could receive travel vaccinations that were available on the NHS.
- Patients were offered extended access appointments at another practice until 8.30pm Monday to Friday as well as weekend appointments as part of hub working arrangements. Extended access appointments could be pre-booked to suit working patients. Reception staff passed patients requiring extended access appointments to the practice manager to arrange.
- The national GP patient survey showed that patient experience for making appointments and satisfaction to appointment times and types were below local and national averages. Some working patients on the NHS choices website also commented that they found access to appointments that suited them difficult.
- The practice told us that they did not offer online appointment booking. They had offered it previously but had decided not to offer this anymore. We were told that patients who were proficient in the use of IT systems were able to book these appointments. However, many of their more vulnerable patients were not as proficient using IT systems and this was having a negative impact on appointment availability for them. Therefore, they had decided against it.

**People whose circumstances make them vulnerable**

**Population group rating: Requires Improvement**

**Findings**

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The Citizens Advice Bureau ran clinics from the practice and other local practices on a rotational basis to provide advice and support on a variety of issues. Citizens Advice Bureau hold clinics at the practice to help vulnerable patients in financial difficulty or facing housing crises.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode. Practice staff told us that they had patients registered from local refuges and that patients could use the practice address to register if necessary.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- As an organisation OHP (Birmingham and Solihull CCG only) have been awarded the contract with the Health Exchange for social prescribing. It is currently being rolled out within the Hall Green locality. The plan is to recruit a Health and Wellbeing Co-ordinator within each locality.

**People experiencing poor mental health (including people with dementia)**

**Population group rating: Requires Improvement**

**Findings**

- Priority appointments were allocated when necessary to those experiencing poor mental health. Care plans were in place for relevant patients.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Extended appointments were available for patients with mental health needs if needed.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

## Timely access to the service

### People were not 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.	Partial
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence:	
<p>We were told that the GP prioritised care and treatment based on clinical needs where relevant. Where patients were unable to obtain an appointment the practice manager would contact patients to arrange appointments. This included access to the extended access appointments. Since October 2018 the practice was able to offer extended access appointments weekdays until 8.30pm and on a weekend at another practice through hub working arrangements. However, there was a lack of clear and consistent processes for this. Following the inspection, we were sent a protocol on how this was managed.</p>	

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)	65.0%	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)	48.9%	62.5%	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)	49.8%	63.0%	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)	59.6%	69.9%	74.4%	No statistical variation

#### Any additional evidence or comments

We received 39 comment cards and spoke with two patients on the day of the inspection. Most patients

told us that they could get an appointment when required. The practice telephone system facilitated identification of those patients that called the surgery but were not able to get through. The practice manager showed us recent data of some patients that had called and how they had followed these patients up with a phone call to ensure their needs were being met.

Although most comment cards were positive about patient experience, three patients also commented that at times it was difficult to get an appointment. We reviewed the NHS choices website and there were some comments related to the lack of access to appointments that suited them, especially from those that worked.

Patient feedback from the national GP patient survey shows that patient experience of making an appointment and satisfaction with appointment times were below local and national averages. The practice was closed for appointments on Wednesday and Friday afternoons. We were told that ad-hoc appointments were offered to patients on Fridays following triage if urgent as the lead GP carried out administration work on site. Afternoon appointment times were from 14.00 to 16.00 on Mondays, Tuesdays and Thursdays only.

Source	Feedback
For example, NHS Choices	There were mixed comments about the service on the NHS choices website. Some were positive while others stated that they found it difficult to access the service.
CQC comment cards	Feedback received from CQC comment cards were very positive about the quality of care received, the staff and service. We received 39 comment cards and whilst all were positive about the service three patients also mentioned that it was occasionally difficult to get access.
Patients	We spoke with two patients and their views aligned with the views we had received through the comment cards.

**Listening and learning from concerns and complaints**

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

<b>Complaints</b>	
Number of complaints received in the last year.	4
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	0
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	<b>Y/N/Partial</b>
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence:	

Example(s) of learning from complaints.

<b>Complaint</b>	<b>Specific action taken</b>
Front car park lights not working	An elderly patient complained that they nearly tripped at the front door because the lights at the front car park were not working. They were the last patient of the day and they were safely escorted out and the practice organised for the lights to be fixed the following day. Staff did not normally use the front car park and so were unaware that lights were not working. As a result, regular checks had been put in place.
Repeat prescription error	Patient complained that they had not received their repeat prescription of controlled drugs. The prescription was collected by another pharmacy and the practice had reviewed its policy with staff to ensure this did not re-occur.

## Well-led

## Rating: Requires Improvement

We rated the practice as requires improvement for well-led services as the overall governance arrangements to support high quality sustainable care was not effective.

### Leadership capacity and capability

**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.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Partial
<p>The provider organisation (OHP) added Poolway Medical Centre to their registration in October 2017. The OHP partnership model is one of local autonomy in which individual practices and the GP partners work to identify their own local priorities and run their practices in the way they see fit to meet their local population needs. The OHP Board takes on a more strategic role. The OHP Board is made up of nine elected GP partners, the Operations Director and Finance Director. Board elections are staggered on a three-year roll. The OHP board held a development event in June 2018 to assess and challenge the effectiveness of the chosen model.</p> <p>There is a small central OHP team that support the practices to achieve future sustainability and resilience. They do this in various ways such as helping to reduce some of the administrative burden in the running of their practice and to help individual practices realise and identify solutions to local challenges (through innovation and effective partnership working). At the time of the inspection, information submitted by the provider showed that Poolway Medical Centre were not fully engaged with the provider's quality assurance processes.</p> <p>We found at practice level local leaders were aware of some of the challenges they faced to quality and sustainability. The GP and practice manager told us that the service had been required to move premises on two occasions which had affected the stability of the service. The lead GP had also been working alone for a significant length of time due to the long-term absence of their GP partner. They told us that when their partner returned they would be able to share responsibilities and work more proactively to improve and deliver a quality service. However, the practice was unable to give any clear date as to when the partner would return.</p>	

### Vision and strategy

**The practice had a 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.	Partial

The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>There was a collective vision among OHP member practices which was to provide: 'A strong and sustainable GP partnership that influences change in health and social care for the benefit of our patients, partners and practices, whilst providing leadership, standards, and support to ensure all we do clinically or operationally is of the highest quality.'</p> <p>The vision and values for OHP and its member practices were set out in the provider business plan. This had undergone annual review with the GP partners to monitor progress of delivery and identify that the direction of travel was still appropriate.</p> <p>The practice told us that they were in the process of reviewing the providers systems, policies and processes but had not had the capacity to review the policies and procedures and adopt those where relevant.</p>	



## Culture

**The practice aspired to deliver high quality care but some aspects of the culture of the practice did not effectively support high quality sustainable care.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	N/A
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Partial
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
Explanation of any answers and additional evidence:	
<p>There was an expectation that practices who wished to join OHP shared the same goals.</p> <p>There were arrangements at provider level to address behaviour inconsistent with the vision and values of the organisation (OHP). Member practices were expected to provide monthly returns of core quality markers which were discussed at the provider governance meetings along with other information such as incidents and complaints. This was used to assure the board of quality standards.</p> <p>There was an OHP whistle blowing policy which allowed staff to refer any concerns directly to the provider if they felt unable to raise them with a local practice. However, not all staff at the practice were able to easily access these policies and procedures.</p> <p>At provider level we saw that there was a strong emphasis on the safety and well-being of staff. One of the providers key objectives was to focus on a sustainable workforce and create better work life balance. This was being delivered through the development of staff retention schemes and sharing some of the administrative burden on practices for example, support with managing finances, development of policies and implementation of governance systems to support practice management. The practice was not fully embedding these systems.</p> <p>Poolway Medical Centre was a small practice with a lead GP, a practice manager, two reception staff and two long term locum GPs. Reception staff members we spoke with told us that the GP and the practice manager were supportive and approachable. They felt they could raise any issues that affected them and were confident action would be taken.</p> <p>We saw that reception staff had limited responsibility and were not always aware of all the practice processes. The running of the service was closely managed by the practice manager and the lead GP partner for Poolway Medical Centre. The risk of this had not been effectively managed.</p>	

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

Source	Feedback
Staff interviews	Staff told us that the GP and the practice manager had an open-door policy and responded to any issues they raised.

**Governance arrangements**

**The overall governance arrangements were ineffective.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	N
<p>Explanation of any answers and additional evidence:</p> <p>Individual practices retained local responsibility and accountability for the services they provided within the OHP provider model. However, there was also a centralised governance function in which the central team monitored quality across the whole organisation and provided the board with assurance that standards at practice level were being maintained. The central team provided a supportive role to practices who needed it. Information seen showed the provider was not regularly receiving quality returns from the practice with which to assure the board.</p> <p>The provider communicated with the practices through the sharing of minutes from board meetings and regular quarterly newsletters which were made available through GP team net. We found GP Team Net was not fully embedded at the practice in order to receive these regular communications.</p> <p>At practice level we found there was a lack of structured governance arrangements. Before the inspection we request all services to submit information such as incident reports, complaints and audits. However, the practice had not submitted any of the information requested, despite being given an extension. On the day of the inspection the practice was unable to provide a significant amount of evidence we asked to see. For example, the practice did not have all available information regarding staff immunisation, appraisal and some evidence regarding recruitment of staff. Much of this was supplied following the inspection. This had also been an issue at our previous inspection in November 2017.</p> <p>Staff members we spoke with told us that they were aware of their roles and responsibilities. However, on the day of inspection reception staff were not always able to demonstrate this. For example, reception staff were unable to access policies necessary for their role. They were unaware of the location of the hearing loop even though it was in the reception room. The incident reporting process to support learning was not well embedded or proactively encouraged. There was limited advanced booking of appointments and reception staff forwarded calls to the practice manager to book appointments when they were unable to fit patients in. This gave the practice management less time to focus on their managerial and governance roles.</p>	

## 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.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
Explanation of any answers and additional evidence:	
<p>Performance and risk was managed at practice level however, the central OHP team maintained an oversight of this. The practices were expected to provide assurance that quality standards were being met and quality and risk was being managed through the submission of core quality markers to the central team. These were monitored along with complaints, significant events and safety alerts through the centralised governance management processes. Evidence submitted by the provider showed that this practice had not engaged with this as they had not submitted any core quality markers, incidents or complaints at the time of inspection. The provider had identified this and had tried to engage with the practice to offer support which had not been taken up. Further action had yet to be decided.</p> <p>At practice level we found systems for managing local risks were not always effective. For example, the principal GP at the practice had not taken leave for many years in the long-term absence of their GP partner. They processed all incoming communications relating to patients. Building work was also being undertaken on the premises however the practice was unable to demonstrate any formal risk assessment to understand and mitigate the risks of this had been undertaken.</p>	

## Appropriate and accurate information

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

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

entails.

Explanation of any answers and additional evidence:

We found information relating to patient care and treatment was appropriate and available in a timely way to support decision making. However, management information was not always well organised or readily available when requested.

GP Team Net (clinical and governance system) had been rolled out across OHP member practices and provided the main forum for sharing management information. This enabled both the practice and central team to manage and monitor information such as those relating to incidents, complaints, safety alerts and staffing. However, we found the practice had not actively embedded this system.

The provider organisation had recently collated performance data from nationally available sources which they had started to share with practices to help them manage their own performance.

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

**The practice involved / did not 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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us that they had recently carried out a patient survey but were unable to show us any evidence to support this.</p> <p>The provider (OHP) held partners meetings annually which provided a forum for provider level feedback and to check that the direction of travel of the organisation was still appropriate. OHP had also set up a salaried GP community and planned to introduce a similar network for nursing staff working across the organisation.</p> <p>The practice was small and we were told by staff that the local management had an open-door policy and they could approach them for any issues and they would be acted on. Non-clinical staff told us that they had staff meetings but these were informal. They were unable to recall when the last meeting was.</p> <p>The centralised OHP team played a significant role in the stakeholder engagement on behalf of member practices. For example, OHP provided a collective voice for GPs in strategic planning within the health and social care economy and for exploring areas for collaborative working.</p>	

Feedback from Patient Participation Group.

Feedback
<p>We were told that there was a virtual patient participation group (PPG) consisting of approximately 12 members but did not see any evidence of engagement. However, the practice told us they had never received any feedback when requested. We saw there was a poster in the reception area encouraging patients to become part of a physical PPG but had not yet received any responses.</p>

## 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.	Partial

Learning was shared effectively and used to make improvements.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>We saw evidence at practice level where audits demonstrated quality improvement. We saw minutes of meetings which shared learning from significant events and complaints although administration staff stated that they had not witnessed any events or were aware of any.</p> <p>Being part of a large provider organisation (OHP) enabled practices to:</p> <ul style="list-style-type: none"> <li>• collectively bid and benefit from new contracts for example, extended access, anticoagulation and social prescribing services.</li> <li>• Share and learn from each other for example, the system for recording and monitoring incidents and complaints management was adopted from a practice within OHP.</li> <li>• benefit from workforce developments including an internal staff bank.</li> <li>• Explore digital access through the provider participation in a pilot scheme.</li> <li>• Focus on improvement and innovation through collaborative working within the practices own locality using General Practice Forward View money. Examples, of improvement schemes have included the development and training of reception clerks in managing prescriptions and improving document handling.</li> <li>• Collaborative working with the hospital and community services to bring services closer to home.</li> </ul>	

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
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.