

Care Quality Commission

Inspection Evidence Table

Pinfold Medical (1-570735489)

Inspection date: 03 and 06 March 2020

Date of data download: 25 February 2020

Overall rating: Requires improvement

We rated the practice as requires improvement overall because:

- The practice's performance for some of the long-term conditions were below the local and national averages, and the target for cervical cancer screening had not been met.
- There was limited evidence of quality improvement activity.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe

Rating: Good

At our inspection in January 2019 we found the practice in breach of regulation 17 for safe.

Specifically:

- Although significant events were discussed and recorded on the log, the information was not always up to date or shared in a timely manner.
- The practice had not ensured the competence of staff employed in advanced roles by audit of their clinical decision making.
- The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to health, safety and welfare of service users and others who may be at risk.

In particular:

- The practice did not have a system in place that demonstrated that alerts which may affect patient safety had been received, recorded and acted upon.
- 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.

At this inspection we found that the provider had satisfactorily addressed these areas and is now rated good overall.

At this inspection the practice had taken appropriate action to meet the requirements of the regulation and had an up to date log and identified actual events and near misses which they recorded as learning events. There was documented evidenced that events were discussed and learning shared. The investigative process did not identify all contributory causes, but the practice had already identified this for themselves and were in the process of deciding which root cause analysis would work for them. Staff employed in advanced roles had their clinical decisions reviewed formally and were supported with informal supervision when required.

The practice had a comprehensive alert system which recorded the alert, who was contacted, action taken, and the practice had plans to ensure it showed when ongoing or repeated audit would be required. Emergency medicines were either stocked as required or had a comprehensive risk assessment in place to explain why they were not in stock.

In addition to the breach of regulation we asked the provider to consider best practice specifically: Review the register of children with child protection plans in place as well as looked after children to ensure the information is up to date and current.

Create and maintain a register of vulnerable adults as appropriate for patients aged over the age of 18 years.

The practice had made improvements to both areas and had improved its safeguarding processes for both adults and children.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in January 2019 we asked the practice to:</p> <ul style="list-style-type: none"> • review the register of children with child protection plans in place as well as looked after children to ensure the information is up to date and current. • Create and maintain a register of vulnerable adults as appropriate for patients aged over the age of 18 years. <p>At this inspection we found that the practice had:</p> <ul style="list-style-type: none"> • reviewed the register of children with child protection plans in place as well as looked after children to ensure the information was up to date and current. Siblings and adults were appropriately identified. • The practice had taken suitable steps to identify vulnerable adults and had developed a register to ensure that these patients were suitably supported. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes

Explanation of any answers and additional evidence: Recruitment checks for locum staff were as detailed and available as those for substantive staff. All records had a comprehensive immunisation record within them. All professional registrations had a reminder built into them a month before they were due, we could see that all clinical staff were registered appropriately.

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: 9/10/2019	Yes
There was a record of equipment calibration. Date of last calibration: 9/10/2019	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: 28/02/2020	Yes
There was a log of fire drills. Date of last drill: 30/04/2019	Yes
There was a record of fire alarm checks. Date of last check: 28/02/2020	Yes
There was a record of fire training for staff. Date of last training: varied dates all staff up to date.	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 31/10/2019	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: The practice had three fire marshals. The fire risk assessment had required the practice to hold a fire evacuation drill every year and record the event. We saw that this had been completed.	
There was also suitable testing in place for legionella and hardwiring.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 19/10/2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 23/10/2019	Yes
Explanation of any answers and additional evidence: The practice had added all their health and safety data onto their commercial practice wide data base. All staff had received training n the new database and the practice were in the process of developing frequently asked questions and answers section for staff.	

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
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 2/3/2020	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: The practice had scored 98% compliance at their most recent infection control audit. They had identified many fabric chairs within the practice. The practice had not yet completed its action plan for how to deal with this issue.	

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
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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
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: <ul style="list-style-type: none"> At our previous inspection in January 2019 the practice had not ensured the competence of staff employed in advanced roles by audit of their clinical decision making. The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to health, safety and welfare of service users and others who may be at risk. 	

- At this inspection the practice had commenced formal monthly supervision of staff in advanced roles and reviewed their clinical decision making.
- At this inspection the practice had carried out a comprehensive set of risk assessments to promote the health, safety and welfare of service users and others who may be at risk.

The practice had shared the recent updates on coronavirus at a recent practice meeting.

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 and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N/A
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: Test results were assigned to the GP that had requested them. The practice had an effective buddy system which ensured that all results were acted on the day of they came to the practice.	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	1.07	0.90	0.87	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). (01/10/2018 to 30/09/2019) (NHSBSA)	8.4%	5.6%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)	6.18	5.29	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	1.57	1.92	2.08	No statistical variation

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

Medicines management	Y/N/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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
Explanation of any answers and additional evidence: The practice held suitable emergency medicines, they had a suitable risk assessment in place for a medicine which blocked the effect of opioid medicines.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong and make 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:	Three
Number of events that required action:	Three
<p>At our inspection in January 2019 we found that:</p> <ul style="list-style-type: none"> Although significant events were discussed and recorded on the log, the information was not always up to date or shared in a timely manner. <p>At this inspection we found:</p> <ul style="list-style-type: none"> Events were now categorised as actual events and near misses which they called learning events. The practice had an up to date log of all types of events and there was documented evidenced that events were discussed and learning shared. However, the practice had identified one event as a near miss which was an event. The investigative process did not identify all contributory causes, but the practice had already identified this for themselves and were in the process of deciding which root cause analysis would work for them. 	

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

Event	Specific action taken
The practice had a looked after child who required a regular medicine. The process for registering looked after children had not been followed and safeguarding had not been advised. There was an incorrect quantity of medication prescribed due to the resultant confusion.	Practice reviewed process and ensured that all staff knew how to register and who to notify when a looked after child joined the practice. The process for ordering prescriptions was explained to all adults involved to reduce risk of recurrence.
Patient with hip pain had received x ray, but local hospital had not reported on fracture.	Local hospital notified by practice when mistake identified. Practice referred patient for specialist surgery.
The practice had two patients with the same name and a similar date of birth. The patient was seen but their prescription was given with the other patients details on it.	The practice corrected the mistake and issued the correct prescription. The practice reviewed process and reminded staff to check date of birth when booking appointments. However, they had not logged this incident as an event appropriately although they had discussed it, documented it and shared the learning.

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
<p>At our previous inspection in January 2019:</p> <ul style="list-style-type: none"> • The practice had not ensured the competence of staff employed in advanced roles by audit of their clinical decision making. • The practice did not have a system in place that demonstrated that alerts which may affect patient safety had been received, recorded and acted upon. • 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. <p>At This inspection we found:</p> <ul style="list-style-type: none"> • The practice had ensured the competence of staff employed in advanced roles with formal clinical supervision. This was recorded on the practice electronic data base. • The practice recorded all alerts, actions taken and had plans to record when further ongoing action or additional searches would be required. • We saw examples of actions taken on recent alerts for example, regarding sodium valproate. • However, the practice still had loop cords for blinds in place, even though there were no blinds. There was a Health and Safety alert in 2010 which required all blind cords to be secured. The practice believed that the cords had been removed with the blinds and asked their landlord to remedy. 	

Effective

Rating: Requires Improvement

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

- There was limited evidence of quality improvement activity.

We also rated two of the population groups as requires improvement. In particular:

People with long-term conditions:

- People with long term conditions had not received an annual review.

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

- Cervical screening rates were below national targets.

Effective needs assessment, care and treatment

Patients' needs were, 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
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
Explanation of any answers and additional evidence: two-week pathway referrals were made by the clinician at the time and choose and book was used for routine non urgent appointments.	

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) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	0.55	0.72	0.74	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.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- Patients with long-term conditions had not all received a structured annual review to check their health and medicines needs were being met. The practice told us they had got a bit behind with this and had built monitoring into their regular meetings.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	67.2%	77.8%	79.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	6.0% (39)	11.6%	12.8%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	66.8%	79.1%	78.1%	Tending towards variation (negative)
Exception rate (number of exceptions).	5.1% (33)	5.5%	9.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	71.8%	81.9%	81.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	5.9% (38)	8.8%	12.7%	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	63.5%	74.7%	75.9%	Variation (negative)

RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) <small>(QOF)</small>				
Exception rate (number of exceptions).	3.7% (23)	2.4%	7.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	94.7%	90.2%	89.6%	No statistical variation
Exception rate (number of exceptions).	2.1% (8)	7.6%	11.2%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	74.9%	82.5%	83.0%	Variation (negative)
Exception rate (number of exceptions).	1.4% (24)	2.2%	4.0%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	89.0%	91.6%	91.1%	No statistical variation
Exception rate (number of exceptions).	0.5% (1)	4.5%	5.9%	N/A

Any additional evidence or comments

The practice's performance on the three quality indicators for diabetes was below the local and national averages. Exception reporting for all three quality indicators was below the local and national averages.

The practice's performance on quality indicators for atrial fibrillation and COPD was in line with the local and national averages, although the performance for hypertension and asthma was below the average. Exception reporting for the quality indicators was below the national averages.

The provider did not have an effective mechanism to follow up on people who had been invited for a long-term condition review. The practice told us that they planned to review their recall policy. The providers current recall policy encouraged people to refuse their appointment and did not identify the benefits of an annual review or encourage patients to attend.

The practice provided unverified data that was more recent than the data presented in the above tables for the diabetes long-term condition indicators. The unverified data suggested that the practice had made improvements.

During the factual accuracy period the provider assured us that they had reviewed their year to date figures for all long-term conditions and felt that they were now on target. We will review these figures at the next inspection.

Families, children and young people

Population group rating: **Good**

Findings

- The practice had met the minimum 90% for four of four childhood immunisation uptake indicators. The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of four childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.

- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception at two other local services.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	106	109	97.2%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	116	122	95.1%	Met 95% WHO based target
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) (01/04/2018 to 31/03/2019) (NHS England)	116	122	95.1%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	116	122	95.1%	Met 95% WHO based target

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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. However, they had not taken steps to monitor how many eligible patients had taken this up.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- The practice had not met the target for cervical screening. The practice did not have a plan in place to meet this target or to proactively encourage uptake of the screening.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 01/07/2019 to 30/09/2019) (Public Health England)	72.9%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	69.7%	69.3%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	53.3%	51.8%	58.0%	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. (01/04/2018 to 31/03/2019) (PHE)	73.1%	73.5%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	35.5%	45.9%	53.8%	Tending towards variation (negative)

Any additional evidence or comments

The practice uptake for cervical screening was 73%, which is below the 80% coverage target for the national screening programme. There has been an improvement in uptake from 70.5% in 2017/18.

Breast and bowel cancer screening rates were slightly below the national average.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term 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.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	73.7%	91.0%	89.4%	Tending towards variation (negative)
Exception rate (number of exceptions).	2.6% (2)	7.2%	12.3%	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 (01/04/2018 to 31/03/2019) (QOF)	98.7%	95.0%	90.2%	Tending towards variation (positive)
Exception rate (number of exceptions).	1.3% (1)	3.8%	10.1%	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 (01/04/2018 to 31/03/2019) (QOF)	76.3%	82.8%	83.6%	No statistical variation
Exception rate (number of exceptions).	9.2% (6)	6.7%	6.7%	N/A

Any additional evidence or comments

The practice's performance in one of the three quality indicators used to monitor the effectiveness of the care and treatment provided to patients with mental health conditions was below the local and national averages.

Exception reporting for the two of three quality indicators was below the local and national averages whilst significantly higher in one of the quality indicators.

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)	512.2	542.6	539.2
Overall QOF score (as a percentage of maximum)	91.6%	97.1%	96.7%
Overall QOF exception reporting (all domains)	4.3%	5.3%	5.9%

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

Quality improvement activity was targeted at the areas where there were concerns.	No
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

The practice had set up a system to monitor its quality indicators and identified that they required a dedicated lead for these areas. However, they were aware that they had not monitored these targets effectively and the registered manager told us that they planned to dedicate more time to the practice in future.

There were clinical and non clinical audits and nursing staff were included in some audit activity. However, improvements in care or treatment were not identified or demonstrated.

The practice participated in the local Clinical Commissioning Group (CCG) Primary Care offer and other CCG led initiatives which included prescribing practice.

Any additional evidence or comments

Although the practice had commenced a series of audits these did not include the number of patients reviewed, nor the actual improvements made. Audits did not identify the number of patients who received a change in treatment as a result of the audit. There was no clear follow up plan for when a second cycle was required, although some audits stated a further cycle was required. There was no dedicated forward audit plan.

During the factual accuracy period the provider sent us a document which detailed their planned second cycles for audit.

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.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: Staff told us they supported to learn and that they also had protected learning time.	

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 (01/04/2018 to 31/03/2019) (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

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
Explanation of any answers and additional evidence: Since our last inspection January 2019 the practice had developed a register of all end of life patients and their life expectancy.	

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	96.9%	96.8%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.8% (20)	0.5%	0.8%	N/A

Consent to care and treatment

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

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

Well-led

Rating: Requires Improvement

At our previous inspection in January 2019, we rated that practice as requires improvement for providing well-led services. This was 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 practice did not have a clear and effective process for managing risks, issues and performance.

Although we found that improvements had been made at this inspection, the practice continued to be rated requires improvement for providing well-led services because:

- There was limited evidence of quality improvement activity and audits did not include the number of patients or what quality improvements had been made to treatments or processes.
- Patients told us that they found the signage, two reception desks and two waiting areas confusing, and some patients were unaware the two practices had merged.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders could not always 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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: Limited progress had been made towards merging to one organisation from the two previous organisations. The practice planned to rotate staff between the two wings to give a more unified approach to one practice.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes

There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: Staff told us that they had felt included in the merger and changes. They felt supported by the changes to practice systems and the new database.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes

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

Source	Feedback
Staff	Staff we spoke with told us that they enjoyed working at the practice and they were listened to. They told us that they had felt involved in the merger of the two practices.
Patients	We spoke with 11 patients during our inspection. However, patients told us that they found the signage, two reception desks and two waiting areas confusing. Some of the patients we spoke with did not know the practices had merged and three of them asked us what that meant.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: The practice had identified the need for a new QoF lead but had not yet completed this. Other clinical roles were clearly identified, and staff knew who to seek advice and support from.	

Managing risks, issues and performance

There were not always clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Partial
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.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>There was a clear programme for non clinical audit to ensure the smooth running of the practice and refine processes. However, clinical audit did not identify the number of patients included in each audit, or what improvements were made to care or treatment.</p> <p>The practice had identified one event as a near miss which was an event. They did not have a clear investigative process to ensure that all contributory causes were clearly identified, and this prevented effective learning.</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.	Partial
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
<p>Explanation of any answers and additional evidence: The practice had identified they had further work to do in relation to QoF and patients with long term conditions. However, they had not completed their plans for this. Although the practice monitored this data frequently their unvalidated results did not indicate improvements in the quality indicators.</p>	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in January 2019 we found that the merged practice was not working as one practice.</p> <p>At this inspection we found that it was unclear to patients that the practice was one merged practice. Although the practice had completed its merger between All Saints Surgery and Field Road on 1 April 2018, they had only changed the name of the merged practice to Pinfold Medical Services in March 2020. Whilst the surgery ran as one patient list many of the patients' we spoke with at this inspection were unsure about the change and did not know about the merger. The practice still had two separate reception desks with their old practice names above the desks, they also had two waiting areas. Electronic check in screens had the new practice name. Patients we spoke with told us that they found the use of three names very confusing. Signage was not clear for new patients who wished to register at the merged practice.</p>	

Feedback from Patient Participation Group.

Feedback
The practice manager had not been able to contact the patient participation group, so we were not able to talk with them at this inspection. We did review minutes from their meetings and saw that they had a large notice board in one of the waiting areas.

Continuous improvement and innovation

There was some 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.	Yes
<p>Explanation of any answers and additional evidence: The practice had developed a programme of practice and clinical meetings which enabled them to share learning in a timely manner.</p> <p>The practice had not developed a forward audit plan and clinical audits did not have the level of detail required to demonstrate improvement.</p>	

Examples of continuous learning and improvement

At this inspection we found that the practice had looked to learn from complaints and recorded verbal and formal complaints.

The practice was committed to supporting first year medical students from a local university. The practice also supported nursing students from another local university.

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 Bands	Z-score threshold
Significant variation (positive)	≤-3
Variation (positive)	>-3 and ≤-2
Tending towards variation (positive)	>-2 and ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

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