Care Quality Commission

Inspection Evidence Table

Collingwood Family Practice (1-5783196318)

Inspection date: 28 January 2020

Date of data download: **06 January 2020**

Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19. The QOF data was collected in relation to the previous provider between April and September 2018 and for Modality Partnership between October 2018 and March 2019.

Please note: The Prescribing data relates to the period 01/102018 to 30/09/2019. Data collected during this period relates to Collingwood Family Practice only.

Safe Rating: Good

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.	Yes
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

Safeguarding	Y/N/Partial

Explanation of any answers and additional evidence:

On 12 December 2019 we undertook a review of the governance arrangements at provider level and reviewed the corporate policies, procedures and systems in place across the organisation. We saw that there was a corporate safeguarding policy and chaperone policy in place.

Staff spoken with during the inspection were aware of the safeguarding lead for the practice and knew where to locate the relevant policies and procedures. Clinical staff shared examples of actions that had been taken in response to safeguarding concerns. Safeguarding was a standing agenda item at clinical and practice meetings.

Bi-monthly meetings were held with the health visitors. Staff told us they could contact the health visitors at any time or advice or support. Children not bought for secondary care appointments or childhood immunisations were monitored, reviewed and where appropriate recalled.
All safeguarding patients were electronically read coded and flagged on the practice clinical system.

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:

On 12 December 2019 we undertook a review of the governance arrangements at provider level and reviewed the corporate policies, procedures and systems in place across the organisation. We saw that there was a corporate recruitment policy in place and the provider operated an on-boarding process for new staff. The on-boarding process involved preparing a new employee to commence work and get settled into the organisation. The provider used an electronic system to record personal information for each employee. Professional registration renewal dates were recorded, and alerts sent to the management team when a registration was due. We reviewed the information for a member of staff who worked in the Walsall Division and saw the registration was up to date.

We looked at three staff files during the inspection, one of whom had been employed since the change in provider. With the exception of references for previously employed staff (removed by the previous provider), all of the required recruitment information had been obtained.

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: 02/09/2019	Yes
There was a record of equipment calibration. Date of last calibration: 02/09/2019	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: June 2019	Yes
There was a log of fire drills. Date of last drill: 06/12/2019	Yes
There was a record of fire alarm checks. Date of last check: 10/04/2019 and weekly testing	Yes
There was a record of fire training for staff. Date of last training: Individual dates for on-line training	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 17/04/2019	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: • We saw areas of the building that would benefit from additional fire exit signs.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: December 2019 / January 2020	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: December 2019 / January 2020	Yes
Explanation of any answers and additional evidence: • The practice manager told us that any actions identified within the risk assessments had been addressed immediately, although this was not recorded on the form.	

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: 12/2018	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:

On 12 December 2019 we undertook a review of the governance arrangements at provider level and reviewed the corporate policies, procedures and systems in place across the organisation. We saw that there was an infection prevention and control policy in place, which included the cold chain policy and procedures.

We saw that the premises were visibly clean and tidy on the day of the inspection. Feedback we gained from patients suggested they were satisfied with the cleanliness of the practice and the hygiene arrangements in place.

The practice had a designated infection prevention and control (IPC) nurse lead. The IPC lead was supported by the health care assistant, who was responsible for completing a range of internal IPC audits. Clinical staff were responsible for maintaining the cleanliness of their consulting / treatment room and equipment and completing the required checklist.

The infection prevention and control audit carried out by the local authority was due to take place on 30 January 2020.

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	Yes

sepsis.	
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: • Reception staff had clear guidance to follow for deteriorating or unwell patients and had completed on line training. • Information relating to sepsis was displayed around the practice.	

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.	Yes
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
Explanation of any answers and additional evidence: We saw systems were in place for the management of test results. All results were reviewed by the requesting GP and tasks sent to reception staff with outcome action if required. A buddy system was in place to cover annual leave. The practice shared information electronically with the out of hours service, via special patient notes. Patients were also supported through the development of advance care plans.	

Appropriate and safe use of medicines

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

Please note: The Prescribing data relates to the period 01/10/2018 to 30/09/2019. Data collected during this period relates to Collingwood Family Practice only.

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)	0.75	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)	5.8%	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)	5.06	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)	0.86	1.92	2.08	Variation (positive)

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.	N/A
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:

On 12 December 2019 we undertook a review of the governance arrangements at provider level and reviewed the corporate policies, procedures and systems in place across the organisation. We saw that there was a corporate medicines management policy in place. This policy covered high risk medicines, repeat prescribing and prescribing and monitoring of controlled drugs. Non-medical prescribers were mentored and had a supervision plan in place, to monitor the quality of prescribing and consultations.

At this inspection, we saw that systems were in place to closely monitor patients on high risk medicines to ensure blood monitoring had been completed prior to prescriptions being issued. The electronic patient records alerted clinicians to review the records prior to issuing a prescription. Reception staff were required to send a medicine management query task to the clinician when prescriptions were requested without the necessary blood monitoring results in place.

The practice had undertaken quality improvement activity in relation to medicines. Audits had been completed on disease modifying antirheumatic drugs (DMARD) and high dose opiate prescribing.

The practice's prescribing of oral non-steroidal anti-inflammatory drugs was below the local and national average. The practice had halved the level of prescribing over the previous 12 month period.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	7
Number of events that required action:	7
Explanation of any answers and additional evidence: • Significant events were discussed at practice level as well as at the monthly Clinical Governance Group (CGG) meetings. This ensured learning was shared within the practice and across the division. • The practice shared learning and changes that had been implemented as the result of a significant event. As a result of a patient remaining on a high-risk medicine longer than initially indicated due to a misunderstanding between primary and secondary care, the practice had developed a protocol. Patients were seen by the GP when high risk medicines were initiated in secondary care, and an end date for the medicines was discussed. The practice pharmacist reviewed the initiation, duration and ongoing monitoring of the patient.	

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

Event	Specific action taken
The practice received notification of the death of a patient in the emergency depart at a local hospital	The practice contacted the hospital on several occasions to check that the information received was correct. The hospital staff confirmed the information was correct. The GP contacted the patient's family as per the bereavement policy and was informed that the patient had been admitted to a ward for treatment. The practice contacted the hospital to inform staff of the error and reported the incident to the Clinical Commissioning Group. The practice also contacted NHS England to reactivate the patient's records.
Patient on a high-risk medicine identified as not being prescribed adequate contraception.	The practice developed a new protocol for the initiation and repeat prescribing in relation to this group of medicines.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	

On 12 December 2019 we undertook a review of the governance arrangements at provider level and reviewed the corporate policies, procedures and systems in place across the organisation. We saw that there was a policy in place for the management of safety alerts. All alerts were recorded on the electronic system (NHS Futures) and included actions plans for each alert received.

We saw during the inspection that safety alerts had been reviewed and appropriate action taken. However, the information was not collated in one place for ease of review. For example: a spreadsheet detailing all the relevant information.

We saw example of action taken on recent alerts. For example: emerade, Slo-phyllin and ranitidine. We saw the actions taken by the practice in relation to the sodium valproate alert, which included repeated searches to identify patients prescribed the medicine.

Effective Rating: Good

Effective needs assessment, care and treatment

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

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

On 12 December 2019 we undertook a review of the governance arrangements at provider level and reviewed the corporate policies, procedures and systems in place across the organisation. We saw that new guidance was discussed at the clinical practice meetings as well as the monthly Clinical Governance Group (CGG) meetings. The new guidance was an embedded document in the minutes of meetings for ease of reference for staff who did not attend the meetings.

We saw from the minutes of clinical meetings that information from the CGG meeting was shared with staff. We also saw that clinical updates and new and revised guidance was discussed with staff during protected learning time as well as in clinical meetings.

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) (NHSBSA)	0.34	0.72	0.74	Tending towards variation (positive)

Any additional evidence or comments
Please note: The Prescribing data above relates to the period 01/10/2018 to 30/09/2019. Data collected during this period relates to Collingwood Family Practice only.

- The practice prescribing rate for hypnotics was below the local and national average and had been consistently below the averages for a period of time.

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. At total of 71 patients had attended for a review, which included a medicine review and falls risk assessment, at the time of the inspection.
- 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: Good

Findings

- Patients with long-term conditions were offered 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.
- There was a long-term condition recall system in place to ensure patients were offered regular reviews. The practice worked closely with the community specialist nurses, such as the diabetic specialist nurse, who carried out clinics at the practice.
- Patients diagnosed with diabetes were offered the opportunity to attend an education programme (DESMOND). Patients identified as pre-diabetic were offered the opportunity to attend a local prevention programme.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Patients with COPD were offered the opportunity to attend the pulmonary rehabilitation groups. One of the practice nurses had visited both local groups and encouraged patients to attend to support their health and wellbeing.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring or home blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	84.2%	77.8%	79.3%	No statistical variation
Exception rate (number of exceptions).	11.4% (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) (QOF)	83.6%	79.1%	78.1%	No statistical variation
Exception rate (number of exceptions).	4.1% (14)	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) (QOF)	79.2%	81.9%	81.3%	No statistical variation
Exception rate (number of exceptions).	7.6% (26)	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 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) (QOF)	72.0%	74.7%	75.9%	No statistical variation
Exception rate (number of exceptions).	2.8% (10)	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) (QOF)	90.8%	90.2%	89.6%	No statistical variation
Exception rate (number of exceptions).	12.1% (12)	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) (QOF)	82.5%	82.5%	83.0%	No statistical variation
Exception rate (number of exceptions).	1.1% (11)	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) (QOF)	91.4%	91.6%	91.1%	No statistical variation
Exception rate (number of exceptions).	1.9% (2)	4.5%	5.9%	N/A

Any additional evidence or comments

The practice's performance on two of the three quality indicators for diabetes were above the local and national averages. Exception reporting for all three quality indicators was similar or below the local and national averages.

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

Families, children and young people Population group rating: Good

Findings

- The practice had exceeded the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all four childhood immunisation uptake indicators. The practice had achieved 100% and immunised all eligible children.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- A dedicated baby clinic was held each week, offering 6-8-week baby health checks and postnatal reviews with the GP, and childhood immunisations with the practice nurse. The health visitor also held a drop-in session at the same time.
- 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.
- Midwife lead clinics were held weekly at the practice.
- 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.
- 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)	50	50	100.0%	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)	46	46	100.0%	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)	46	46	100.0%	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)	46	46	100.0%	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

Any additional evidence or comments
Please note: The child immunisation data above relates to 2018/19. The data collected between April and September 2018 relates to the previous provider and between October 2018 and March 2019 to Modality Partnership.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (31/03/2019 to 30/06/2019) (Public Health England)	82.1%	N/A	80% Target	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	77.8%	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)	59.7%	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)	83.9%	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)	63.3%	45.9%	53.8%	No statistical variation

Any additional evidence or comments

Please note: The cervical cancer screening data relates to period between 31/03/2019 and 30/06/2019 and is for Collingwood Family Practice. The breast and bowel cancer screening data and number of new cancer cases collected between April and September 2018 relates to the previous provider and between October 2018 and March 2019 to Modality Partnership.

The practice actively promoted the national screening programmes. The practice had met the 80% target for cervical cancer screening. Breast and bowel screening uptake was above the national averages and the practice followed up patients who did not participate in the programmes. The practice told us they continued to promote the screening programmes and hoped to increase patient uptake in the future.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- The practice had identified 17 patients with a learning disability. All patients with a learning

disability were offered an annual health check. The specialist learning disability nurse was supporting the practice with these checks.

- 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 maintained an end of life register, and patients were risk assessed according to level of need. The palliative care lead attended two monthly meetings with the multidisciplinary team to discuss the care of these patients.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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.
- Patients identified as living with dementia were offered an annual review, and 70% of these patients had attended for a review during 2019/20.
- 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)	100.0%	91.0%	89.4%	Variation (positive)
Exception rate (number of exceptions).	7.1% (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)	100.0%	95.0%	90.2%	Variation (positive)
Exception rate (number of exceptions).	7.1% (2)	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)	87.5%	82.8%	83.6%	No statistical variation
Exception rate (number of exceptions).	8.6% (3)	6.7%	6.7%	N/A

Any additional evidence or comments
The practice's performance on quality indicators used to monitor the effectiveness of the care and treatment provided to patients with mental health conditions was above the local and national averages. Staff shared an example of how the whole staff team had supported a patient who presented at the surgery in crisis, prior to being seen by the GP.

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	559.0	542.6	539.2
Overall QOF score (as a percentage of maximum)	100.0%	97.1%	96.7%
Overall QOF exception reporting (all domains)	5.0%	5.3%	5.9%

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

Quality improvement activity was targeted at the areas where there were concerns.	Yes
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

There was evidence that quality improvement activity had been undertaken. The practice had undertaken six recent clinical audits, which were linked to best practice guidelines.

One audit looked at patients prescribed high dose opiates (>110mg) for non-palliative chronic pain. The first cycle identified patients who received over the specified dose of opioid medicine. Seven patients were identified, two of which were excluded due to their medical condition. The remaining five patients were invited in a for a medicine review and discussion around pain management. The second cycle identified that the medicine dosage had been reduced for three patients, a referral to the pain clinic made for one patient, and the remaining patient had left the practice. Ongoing action had been identified and there were plans to re-audit in April 2020 to identify patients prescribed >90mg, invite them for a review with a GP and use the five practical steps to reduce high dose opioids as recommended by the Oxford Pain Management Centre.

The second activity looked at whether patients prescribed non-steroidal anti-inflammatory medicine (NSAIDs) were also prescribed gastro protection medicine, according to their level of risk. The practice identified patients prescribed NSAIDs who should also be prescribed gastro protection medicine. Those patients not prescribed gastro protection medicine were invited in for a medicine review and were subsequently offered the appropriate medicine.

The practice had also carried out an audit on disease modifying antirheumatic drugs (DMARD). The practice had identified patients prescribed a specific medicine to ensure shared care agreements were in place, blood monitoring was taking at appropriate intervals and the results were reviewed by a GP prior to prescriptions being issued. The practice planned to repeat the audit for three more specific medicines.

Any additional evidence or comments

The GPs reviewed all discharge summaries and reviewed any changes in medicines. The practice shared an example of a patient with repeated admissions and following discussions with the patient and their family identified that additional support was required, and a referral to the rapid response team was made.

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:

On 12 December 2019 we undertook a review of the governance arrangements at provider level and reviewed the corporate policies, procedures and systems in place across the organisation. We saw that there was an induction policy in place, which each practice personalised. Non-medical prescribers were mentored and had a supervision plan in place, to monitor the quality of prescribing and consultations.

All staff had an annual appraisal, during which training, and development needs were discussed. The practice supported continuous professional development for clinicians and provided protected learning time for all staff.

Staff spoken with told us they were provided with protected learning time, and that they had been offered the opportunity to develop their skills, for example, training to become health care assistants.

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	Yes

31/03/2019) (QOF)	
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes
Explanation of any answers and additional evidence: The clinicians who reviewed patients via video consultation had full access to electronic patient records and were able to make referrals for patients to other services.	

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: Patients were signposted to local services for support to live healthier lives. The local pharmacy offered smoking cessation services, and patients had access to One You – Walsall, a free health lifestyle service dedicated to improving the health and wellbeing of local people. Patients with long term conditions were referred to local prevention programmes.	

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) (QOF)	97.4%	96.8%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.1% (2)	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

Explanation of any answers and additional evidence:

On 12 December 2019 we undertook a review of the governance arrangements at provider level and reviewed the corporate policies, procedures and systems in place across the organisation. We saw that a consent policy was in place, supported by consents forms where appropriate. Verbal consent was recorded in the electronic patient record.

We saw during the inspection that staff had completed training on the Mental Capacity Act. We saw an example where the practice had supported the family of a patient who lacked capacity to make decisions and develop plans for the patient's future care, in the best interest of the patient.

Patients who used the video consultation service were required to provide proof of identity prior to the consultation taking place.

Caring Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
Explanation of any answers and additional evidence:	

CQC comments cards	
Total comments cards received.	32
Number of CQC comments received which were positive about the service.	23
Number of comments cards received which were mixed about the service.	7
Number of CQC comments received which were negative about the service.	2

Source	Feedback
Interviews with patients	We spoke with one patient during this inspection. They told us they were extremely satisfied with the service provided and always were treated with kindness and respect. They told us staff were kind, respectful and very helpful.
CQC comment cards	Thirty-two comment cards were completed by patients. Patients described the the staff as very caring and helpful, and commented highly about on the service provided by the GPs and nursing team. Comments about the GPs included that they were very thorough, demonstrated empathy and compassion. Patients were complimentary about the care and support provided to them but especially to families with additional needs. The negative comments included on the comment cards were about the challenges of getting an appointment. One patient commented that the practice had greatly improved since the two permanent GPs had joined the practice.
NHS Website	Thirteen reviews had been posted on the NHS website since the change in provider in October 2018. The practice had responded to comments. Five comments were positive (4 or 5 star), one was neutral (3 star) and seven were negative (2 or 1 star). The positive reviews related to good care and treatment, and professional and caring staff. Negative comments included rude and unhelpful reception staff, and a lack of support and empathy.

National GP Survey results

Note: The 2019 GP survey was completed during January and March 2019. At this time Collingwood Family Practice was registered as part of Modality Partnership. However, it should be noted that patients may be commenting on their experience under the previous provider.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5042.0	281.0	103.0	36.7%	2.04%

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 (01/01/2019 to 31/03/2019)	86.2%	87.3%	88.9%	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 (01/01/2019 to 31/03/2019)	85.2%	86.2%	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 (01/01/2019 to 31/03/2019)	92.5%	95.0%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	75.4%	81.6%	82.9%	No statistical variation

Any additional evidence or comments
The national GP survey results indicated that patients were satisfied with the healthcare professionals at the practice, in relation to being listened to, treated with care and concern and having confidence and trust in the health care professionals. The practice results in these areas were similar to the local and national averages. However, patients were less satisfied with their overall experience of the practice. The provider had reviewed the GP survey results and identified that patient satisfaction with their overall experience had decreased slightly from the previous year's results. An action plan had been developed which included the increased use of digital technology, an increase in telephone consultations, recruitment of allied healthcare professionals and aimed to become a training practice. They also identified that patient satisfaction of the perception of their care had decreased slightly and had addressed this through the recruitment of an additional salaried GP, to reduce the use of locum GPs.

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

Any additional evidence
The practice obtained feedback from patients through the Friends and Family Test and comments and suggestions.

Involvement in decisions about care and treatment

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

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

Source	Feedback
CQC Comment Cards	Thirty-two comment cards were completed by patients. Patients commented they were listened to and provided with appropriate information and advice. They felt involved in their care.
NHS Website	Thirteen reviews had been posted on the NHS website since the change in provider in October 2018. The practice had responded to comments. Five comments were positive (4 or 5 star), one was neutral (3 star) and seven were negative (2 or 1 star). The positive reviews related to good care and treatment, and professional and caring staff. Negative comments related to rude and unhelpful staff, and a lack of support and empathy.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	93.3%	92.3%	93.4%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	No
Information about support groups was available on the practice website.	Yes
Explanation of any answers and additional evidence: • The majority of the practice population spoke English as their first language, and information leaflets were available in English. • Staff told us they had to access to interpretation services as required. • The practice did not have a hearing loop to support patients with hearing impairment, but the practice had plans to purchase one.	

Carers	Narrative
Percentage and number of carers identified.	The practice population was approximately 5,042. The practice had 93 identified carers. This represented 1.8% of the practice population.
How the practice supported carers (including young carers).	The practice had a Carers Champion responsible for maintaining the carers register. The practice had been proactive in identifying and coding carers and doubled the number of identified carers. Staff also organised a carers café once a month at the community centre in which the practice was located. The practice had plans to invite a representative from the Walsall Carers Centre to a meeting in March 2020.
How the practice supported recently bereaved patients.	Bereaved relatives were sent condolence cards and information about support was available. Examples of how staff supported bereaved patients was shared during the inspection.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Yes
Consultation and treatment room doors were closed during consultations.	Yes

A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence: • There was a notice on the reception desk requesting patients stand away from the desk to afford the person in front of them privacy when speaking with reception staff. • Telephones were answered away from the reception desk. • Seating in the main waiting area was located away from the reception desk and background music was played, reducing the risk of conversations being overheard.	

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Explanation of any answers and additional evidence:	

Responsive Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

Explanation of any answers and additional evidence:

- The practice was located within a community centre. Access to and around the building was suitable for patients for mobility needs or people with pushchairs. Patient facing areas were located on the ground floor.
- Individual arrangements were in place to support patients with specific communication needs.
- The practice understood the demographics of the practice population, and the higher than average number of patients aged 65 years and over. Consequently, the practice was prioritising identifying patients with severe and moderate frailty and reviewing patients with polypharmacy.

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Number of GP Appointments available:	
Monday	53 + 15 Push Doctor
Tuesday	57 + 15 Push Doctor
Wednesday	71 + 15 Push Doctor
Thursday	67 + 15 Push Doctor
Friday	52 + 15 Push Doctor
Number of Nurse Appointments available:	
Monday	36
Tuesday	38
Wednesday	34

Thursday	25
Friday	14
Number of Health Care Assistant Appointments available:	
Monday	32
Tuesday	19

- The practice employed the services of another provider (WALDOC) for appointments and home visits between 1pm and 2.30pm every weekday and from 1pm to 6.30pm on Thursdays.
- The practice offered early morning appointments between 7.30am and 8am on Mondays and Tuesdays with the practice nurse, and evening appointments with the GP on Wednesdays until 8pm.

Extended GP Access Service

Patients had access to the Extended GP Access Service. Appointments with GPs were available at four hubs within the locality: Darlaston Health Centre, Pinfold Health Centre, Broadway Medical Practice and Portland Medical Practice.

Extra GP appointments were available between:

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

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

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

The NHS 111 service was also able to book appointments on behalf of patients.

National GP Survey results

Note: The 2019 GP survey was completed during January and March 2019. At this time Collingwood Family Practice was registered as part of Modality Partnership. However, it should be noted that patients may be commenting on their experience under the previous provider.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
5042.0	281.0	103.0	36.7%	2.04%

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 (01/01/2019 to 31/03/2019)	92.5%	93.3%	94.5%	No statistical variation

Older people — Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- The practice worked closely with multidisciplinary team to support patients in the community.
- Weekly dosette boxes were prescribed to aid compliance with medicines.

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

Findings

- Patients with multiple conditions had their needs reviewed in one appointment, whenever possible.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- 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 offered a weekly warfarin anticoagulation clinic, enabling patients to be monitored, have blood results reviewed, and prescriptions issued by the GPs.
- The practice provided in-house electrocardiogram (ECG) which is a test used to check the rhythm and electrical activity of the heart.

- The practice provided an in-house phlebotomy (blooding taking) service.

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

Findings

- GP appointments were available until 8pm on Wednesdays for all patients, including school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary, following discussions with the on-call GP.
- The practice had contact with health visitors during the regular safeguarding meetings, as well as through health visitors clinics held within the building.

Working age people (including those recently retired and students) — Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open from 7.30am on Monday and Tuesday for practice nurse appointments, and until 8pm on a Wednesday for GP appointments.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice offered daily non-urgent virtual appointments (via a smart phone app) between 9am and 5pm.
- Pre-bookable appointments were available to all patients at additional locations within the area, through the Extended GP Access Service. Appointments were available between 6.30pm and 9pm on weekdays, between 10am and 3pm on Saturday and Sunday, and 11am and 1.30pm on bank holidays.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability, identified as requiring end of life care, and potential substance misuse.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- Staff prioritised appointments for patients identified on the end of life register.
- The practice had appointed an Armed Forces Veterans champion. At the time of the inspection, the practice had identified three veterans. The champion planned to contact these patients and invite them in to discuss the support available to them.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. Patients were offered extended appointments and annual reviews.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly. Patients were able to self-refer to talking therapies.

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes
Explanation of any answers and additional evidence: The practice offered on the day and pre-bookable appointments with the GPs, as well as video consultations via a smart phone app (Push Doctor). A face to face appointment for patients seen via video consultation was available every day.	

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 (01/01/2019 to 31/03/2019)	74.8%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	61.1%	65.1%	67.4%	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 (01/01/2019 to 31/03/2019)	62.1%	65.2%	64.7%	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 (01/01/2019 to 31/03/2019)	64.9%	69.8%	73.6%	No statistical variation

Any additional evidence or comments
The national GP survey results indicated that patient satisfaction with getting through to the practice by telephone was above the national average. However, patients were less satisfied with their overall experience of making an appointment, the type of appointment and appointment times. These results were below the local and national averages. The provider had reviewed the GP survey results and an action plan had been developed. This included the further promotion of video consultations to enable greater flexibility of appointment times.

Source	Feedback
CQC comment cards	Thirty-two comment cards were completed by patients. Three patients commented that the GPs and nurses were always available for help and support. Patients said they were able to get a same day appointment or telephone consultation if required. However, nine patients commented on the challenges of getting an appointment.
NHS Website	Thirteen reviews had been posted on the NHS website since the change in provider in October 2018. The practice had responded to all comments. Five comments were positive (4 or 5 star), one was neutral (3 star) and seven were negative (2 or 1 star). Four reviews commented on the difficulties getting an appointment.
Information received by CQC	Information had been shared with CQC regarding appointments and a general decline since the change in provider.

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	5
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	5
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Explanation of any answers and additional evidence:

Patients had access to a complaints leaflet. However, there was no information on display in the waiting areas on how to make a complaint.

Only one of the complaints received by the practice had been responded to in writing, as the lead GP tended to contact patients by telephone to discuss complaints and provide feedback. We saw that the written response demonstrated duty of candour and details of how to contact the PHSO if not satisfied with the outcome.

Example of learning from complaints.

Complaint	Specific action taken
Delay in arrive of the ambulance requested by the GP following a home visit	The practice had reviewed the procedures in place for supporting patients waiting for an ambulance to transport them to hospital. They had developed an information leaflet for patients on the next steps if the patient's condition deteriorates whilst waiting for an ambulance. The practice was also implementing the use of a scoring system to aid clinicians assess the urgency for the transfer to hospital.

Well-led Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes

Explanation of any answers and additional evidence:

- In September 2018, the management of the practice changed to Modality Partnership. The provider demonstrated that they understood the challenges to quality and sustainability of the practice and identified the actions needed to address these challenges.
- The provider was aware of the need for clinical leadership and oversight within the practice, and one of existing partners with Modality had provided support to the existing clinical staff, including the nursing team.
- The provider had successfully recruited additional salaried GPs and one of the GPs had recently become a partner.
- Staff reported that they felt well led and part of a team. There was strong collaboration and support across the staff group and a common focus on improving the quality of care and people's experiences.
- All staff were invited to regular practice meetings, including daily huddles, and encouraged to contribute their views and suggestions. Minutes of meetings were shared with all staff.

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:

- The provider had clear values and vision. The vision was to be a leader in delivering resilient

community-based services to improve population health across the system. The values of the provider were based around the word ‘care’ – commitment, accountability, respect and excellence. The values had recently been displayed around the practice.

- Staff spoken with were aware of the vision and their role in achieving it.

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

Explanation of any answers and additional evidence:

- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- The provider had a range of initiatives to support the safety and well being of staff. The practice operated a zero-tolerance policy for violence or aggression towards staff. The provider offered staff discounts on a range of products and shops and an employee support service as well as care awards and long service awards.

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

Source	Feedback
Staff interviews	• Staff reported that they were proud of the organisation as a place to work and spoke highly of the culture. • Staff told us they received informal support when required and could request learning and development at any time. • Staff felt they were treated equally. • Staff reported that the GPs were accommodating and would see patients of concern when requested.

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:

On 12 December 2019 we undertook a review of the governance arrangements at provider level and reviewed the corporate policies, procedures and systems in place across the organisation. We saw that communication systems were in place at all levels within the organisation. Information from board level was cascaded through medical director meetings, clinical governance group meetings and practice level meetings. During the inspection we reviewed whether the governance arrangements had been implemented and embedded at practice level.

- We saw that the governance arrangements in place were working effectively in this practice.
- Communication within the practice was effective, through the meeting structure, which included the daily huddle, used for sharing information on a daily basis. All meetings were minuted and shared with staff.
- There was clear oversight of outstanding work, staff performance, management of risks and quality of care.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

Explanation of any answers and additional evidence:

On 12 December 2019 we undertook a review of the governance arrangements at provider level and reviewed the corporate policies, procedures and systems in place across the organisation. We saw that the provider had systems in place to identify, manage and mitigate risks. During the inspection we reviewed whether the arrangements had been implemented and embedded at practice level.

- Staff we spoke with demonstrated a clear understanding of identifying, reporting and escalating risks and were trained in the event of a major incident. Significant events were shared practice and organisational levels and discussed in meetings held.
- Performance was a standing agenda items at clinical and practice meetings and updates on the Quality and Outcome Framework (QoF) was discussed.
- The practice had a programme of clinical and internal audit, which demonstrated quality improvements for patients.

Appropriate and accurate information

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

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

Explanation of any answers and additional evidence:

On 12 December 2019 we undertook a review of the governance arrangements at provider level and reviewed the corporate policies, procedures and systems in place across the organisation. We saw there were systems in place to monitor performance, for example the dashboard. Performance was discussed at the monthly Clinical Governance Group meetings, attended by the practice clinical leaders.

During the inspection we saw that the arrangements had been implemented and embedded at practice level.

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Any unusual access was identified and followed up.	Yes

Explanation of any answers and additional evidence:

On 12 December 2019 we undertook a review of the governance arrangements at provider level and reviewed the corporate policies, procedures and systems in place across the organisation. Modality Partnership worked with an external organisation (Push Doctor) to provide video consultations for patients. Assurances had been provided that the required checks had been completed for clinicians employed by Push Doctor. Patients who used the service were required to provide identification prior to any consultation taking place. The clinicians were able record information directly into the electronic patient record.

Systems were in place to monitor the quality and usage of this service. Modality and Push Doctor held monthly meetings to discuss significant events and complaints. A weekly dashboard of service was shared with Modality. All patients were asked to complete a satisfaction survey after each consultation.

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
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

Explanation of any answers and additional evidence:

- Information about the PPG was on display in the waiting area and on the practice website.
- Patient feedback was promoted though Friends and Family Test returns, complaints, suggestion

box, compliments and discussions with the practice's patient participation group (PPG).
- Staff told us they were able to make suggestions to management about the delivery of service and these were listened to and acted upon whenever possible.

Feedback from Patient Participation Group.

Feedback
We spoke with a representative from the PPG during the inspection. They told us that there had been a considerable change in attitude towards the PPG following Dr Sidhu's appointment. They told us they had developed a good working relationship with the practice management, and that a GP always attended the meetings. They were encouraged that the group would be able to further develop their support role for the practice. At a recent meeting, they had discussed holding a health promotion/awareness events, continued promotion of cancer screening programmes, flu clinics and the video consultation service. They told us the group was informed of any changes, for example, extended hours appointments being provided on a weekday rather than at the weekend. The PPG member acknowledged the group is very small and not representative of the practice population. However, they told us the promoted the PPG through the PPG corner in the waiting room and discussions with patients.

Any additional evidence
The practice worked closely with the local community. The practice supported charity events, for example, Macmillan coffee mornings, and the local carers café.

Continuous improvement and innovation

There were of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes

Explanation of any answers and additional evidence:

- Learning from audits, significant events and complaints was shared across the staff team, the division and nationally.
- Staff were encouraged and supported to develop their skills and knowledge. For example, reception staff had been offered the opportunity to train to become health care assistants.
- Although the patient uptake rates for cervical, breast and bowel screen were good, the practice planned to further improve these through health promotion/awareness events.

Examples of continuous learning and improvement

- The practice had signed up to participate in the CCG pilot to implement E-consult.
- The practice was aiming to become a training practice for GPs.
- Review of patients with polypharmacy.
- Working with the local Primary Care Network in supporting a clinical pharmacist and social prescriber.
- The practice had applied for a child health practitioner. This was a new service commissioned by mental health services, to be housed in GP practices to assess and triage mental health needs in children.
- The practice had participated in the National Cancer Diagnosis Audit. As a result of the interim findings the practice was implementing a number of initiatives:
    - all new cancer diagnoses were discussed at the clinical meetings,
    - implementation of the use of electronic templates to aid diagnosis,
    - clinicians to completed specific training to aid diagnosis (Gateway C courses)
    - health awareness events for bowel and breast screening.

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 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.