

Care Quality Commission

Inspection Evidence Table

Halcyon Medical Limited (1-515015235)

Inspection date: 4 and 6 July 2022

Date of data download: 30 June 2022

Overall rating: Requires improvement

At the previous inspection in November 2021, the practice was rated Inadequate overall. Following this inspection in July 2022 the practice is now rated Requires improvement.

Safe

Rating: Requires improvement

At the previous inspection in November 2021, the practice was rated Inadequate for providing safe services. Following this inspection in July 2022, the practice is now rated Requires improvement.

The provider had made improvements to safeguarding processes, recruitment processes and systems to assess, monitor and mitigate risk related to premises. However, during this inspection we found systems to manage Patient Group Directions, staff absences, and significant events were not effective or fully embedded.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	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
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
Explanation of any answers and additional evidence:	

Safeguarding	Y/N/Partial
<p>Following the previous inspection in November 2021 the provider had improved their safeguarding policy and processes.</p> <p>We found staff had received safeguarding training relevant to their role.</p> <p>From staff files that we viewed, we found that Disclosure and Barring Service (DBS) checks were undertaken where required. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.</p> <p>From meeting minutes we viewed, we saw the practice communicated with relevant professionals to keep patients safeguarded from abuse and harm.</p> <p>The practice used appropriate clinical codes and had registers in place, to help identify patients and keep them safeguarded from abuse.</p>	

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 UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Following the previous inspection, the provider had used an external recruitment company to help improve their recruitment processes.</p> <p>We reviewed four staff files. The files were organised and contained relevant information. However, the files we viewed contained contracts that had not been signed by staff.</p> <p>Following the inspection, the provider told us the external recruitment organisation had recently re-issued all staff contracts, at the time of the inspection, staff were still reading through terms and conditions before signing and returning back to the provider.</p> <p>The provider had improved their processes, and we found from files that we viewed, all files contained information about staff vaccination relevant to the role.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 5 April 2022	Yes
There was a fire procedure. Date of fire risk assessment: 22 September 2021	Yes
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Following the previous inspection, the provider had improved its systems and processes to manage risk related to the premises.</p> <p>We found a health and safety risk assessment had been carried out by an external company. We saw that immediate actions had been completed and there were dates for when remaining actions would be completed.</p>	

The practice had also completed a premises risk assessment in January 2022 and a security risk assessment in June 2022. We saw that action plans for these risk assessments had been updated to show that actions (where relevant) had been completed.

We saw that most actions from the fire risk assessment in September 2021 had been completed. There were two actions remaining, these were related to the second fire escape route. We saw evidence of the practice liaising with a company to make the necessary repairs.

The practice had completed a COSHH (control of substances hazardous to health) risk assessment and staff had access to safety sheets.

The practice had completed an internal risk assessment in April 2022 to assess and manage risks related to Legionella. Legionella is a bacterium that can contaminate water systems. We saw the practice had arranged for an assessment to be carried out by an external company and in the meantime were carrying out regular water testing to minimise risks. We found however, that monitoring charts were not being completed with relevant information and did not allow for the practice management team to effectively monitor for risk.

Following the inspection, the provider told us any temperatures that fell outside of optimal range would have been recorded on the chart and any temperatures that fell within the optimal range were marked with a cross to say the temperature had been recorded. However, they told us they would review their process further including going forward, they would record the actual temperatures for all checks.

We saw the practice had three designated fire marshals and they had completed the necessary training.

The practice's fire safety policy indicated all three marshals would be involved in any fire evacuation procedure. From evidence we reviewed we found that all three designated fire marshals were not on site every day when the practice was open. The practice did have arrangements in place for other staff to lead an evacuation if needed in the event of all three fire marshals not being available, however these additional staff had not completed the required training.

Information we viewed showed the practice had processes to inspect firefighting equipment, the fire alarm and emergency lighting.

The practice had carried out a fire drill in line with their policy and staff reported there had been no issues during the drill.

We saw the lift had been serviced and the practice was dealing with any outstanding actions following the service.

The practice could demonstrate that equipment had been tested and calibrated and was safe to use.

Infection prevention and control

The provider had improved infection, prevention and control processes.

Y/N/Partial

Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit 31 March 2022	
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Following the previous inspection, the provider had improved their systems and processes to manage infection prevention and control (IPC).</p> <p>We found there was a lead for IPC and that staff had received relevant training for their role.</p> <p>The practice had carried out an IPC audit in March 2022.</p> <p>We saw from the IPC action plan, most actions had been completed. For any actions remaining, the practice had a plan in place, and the lead was monitoring that actions were completed.</p> <p>During our visit, from the areas that we viewed, we found the practice to be visibly clean.</p> <p>The practice had implemented processes to safely manage healthcare waste. We saw that clinical waste bins were stored in a secure area and that sharps bins were labelled and stored correctly.</p>	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	No
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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 were enough staff to provide appointments and prevent staff from working excessive hours	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the time of the inspection, the practice manager, in agreement with the provider, was not at the practice full time. We saw there were arrangements in place to provide practice management in their absence.</p> <p>Some staff we spoke with told us they still felt overwhelmed with the amount of work and staff shortages at the practice and did not feel there had been any significant changes to their workload following the previous inspection. Despite the provider recruiting a part time healthcare assistant (two days a week) and three more administration staff. We saw evidence from meeting minutes that staff were advised they could complete training at home and claim overtime. This indicated there may not be enough staff to allow staff to complete training at work.</p> <p>Staff told us they were not always able to take leave and when staff were off sick, that staff member's duties were not given to other staff to carry out. Staff were not always told by the management team when a staff member was off sick, so they did not always know which duties needed to be reallocated.</p>	

For example, one of the clinical team had been off for three weeks at the time of the inspection and their clinical and non-clinical duties had not been re-assigned to other staff in an organised way.

Staff told us they were advertising for four more non-clinical staff and they were trying different routes to advertise as they had not been successful following the most recent advert.

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
Referrals to specialist services were documented, contained the required information 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
Explanation of any answers and additional evidence:	

Appropriate and safe use of medicines

The practice mostly 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) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.21	0.81	0.79	Significant Variation (positive)
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). (01/04/2021 to 31/03/2022) (NHSBSA)	7.1%	6.2%	8.8%	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 (01/10/2021 to 31/03/2022) (NHSBSA)	5.09	5.21	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	24.8‰	138.1‰	128.2‰	Significant Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.22	0.66	0.60	Variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	4.4‰	8.7‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

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).	Partial

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
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 and Improvement 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 UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The provider had improved arrangements for storage of medicines, vaccines and prescriptions. At this inspection we found these were all stored securely and there were processes in place to monitor their use.</p> <p>We looked at a random sample of five Patient Group Directions (PGDs) and found they either had not been dated or signed by the clinician with responsibility for signing these documents. PGDs give staff the appropriate authorisations they need to administer medicines.</p> <p>Following the inspection, the provider told us the PGDs we reviewed had all been signed and dated correctly to give proper authorisation to administer medicines.</p> <p>The practice could not demonstrate they had systems in place to provide formal clinical supervision to all non-medical prescribers. The provider told us the practice nurse prescribed a limited amount of medicines and had access to support from the on call duty GP, however there was no monitoring of prescribing decisions.</p>	

Medicines management**Y/N/Partial**

Following the inspection, the practice sent evidence of clinical supervision arrangements in place for the pharmacist who was employed by the Primary Care Network (PCN).

Track record on safety and lessons learned and improvements made

The practice had made improvements but could not fully demonstrate they had systems to learn 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.	Partial
Number of events recorded in last 12 months:	Six
Number of events that required action:	Not known
<p>Explanation of any answers and additional evidence:</p> <p>During this inspection we spoke with staff about incidents that had occurred between August 2021 and July 2022. Staff told us there had been five significant events reported since the last inspection in November 2021. From evidence the provider gave us we saw there had been one significant event in August 2021, however we were not provided with any details regarding the five significant events that had occurred after November 2021. The provider did not provide any evidence to demonstrate the significant events had been discussed, and any subsequent learning shared with staff.</p> <p>We saw that the incident in August 2021 had been discussed and an action plan agreed to improve quality of care.</p> <p>We saw the provider had reviewed the incidents that had occurred between September 2020 and August 2021 to identify themes.</p> <p>We were provided with an example of a significant event that occurred in October 2021, we saw this had been discussed in the clinical meeting. However, this had not been included in the provider's analysis of events occurring in 2021.</p> <p>The management team told us that significant events were recorded onto an electronic system called Datix, however they were not able to fully demonstrate how information was shared within the practice. Staff reported that staff meetings had recently been introduced and meeting minutes were emailed to them if they were not able to attend. We saw evidence of one meeting for administration staff in May 2022 and one practice meeting in June 2022. There had been two clinical meetings, one in May and then in July 2022. We saw that discussion of significant events was included on meeting agendas however there was no details in the minutes of any significant events being discussed.</p>	

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

Event	Specific action taken
Non-clinical staff shared incorrect information with a patient	Details for this incident were not available to view.

Patients record had not been updated correctly.	Training was provided to clinical staff.
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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: Our clinical searches indicated the provider had implemented processes to receive and respond to safety alerts.	

Effective

Rating: Requires improvement

At the previous inspection we rated the practice as requires improvement for providing effective services. The practice is still rated Requires improvement for providing effective services.

The provider could not demonstrate they had formal processes in place for clinical supervision for all non-medical prescribers. The practice had not achieved minimum uptake targets for four of five children's immunisations and cervical cancer screening uptake had reduced further. The provider could not demonstrate they had delivered an effective vaccination program for patients requiring shingles and pneumococcal vaccines or effectively delivered NHS health checks.

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

Patients' needs were not always assessed, and care and treatment was not always 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 had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence: At this inspection we found all staff had completed relevant sepsis awareness training. The practice staff told us the turnover in patients registering and de-registering with the practice was high, however, they provided evidence to show their system to monitor the patients that had left the practice and then return their clinical records, had improved.	

Effective care for the practice population

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.
- Frailty assessments were offered to patients over 75 years of age.
- The practice could not demonstrate they had offered shingles and pneumonia vaccinations to all relevant patients in this age group.
- The practice had delivered four out of 95 (4%) required vaccinations for shingles between April 2021 and March 2022. The practice had delivered 166 out of 271 (61%) pneumococcal vaccinations.
- The practice could not demonstrate that patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. The practice had 1157 patients that required a health check. Data showed they had completed three health checks between April 2021 and March 2022 and 14 completed between April 2022 up until the time of the inspection.
- 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 did not have a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice could not demonstrate that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- Our clinical searches and record reviews indicated that patients with long term conditions were followed up in line with national guidelines and received appropriate monitoring.
- 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.
- 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 COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	41	41	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	42	50	84.0%	Below 90% minimum
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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	42	50	84.0%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	43	50	86.0%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	12	21	57.1%	Below 80% uptake

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

The practice had not met the minimum 90% indicator for four of the five childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of the five childhood immunisation uptake indicators.

We found the practice had appropriate systems in place to monitor those patients that needed immunisations, systems for calling them in for appointments and then escalating to the safeguarding lead if patients did not attend for their appointment.

Staff told us they had been asked by the provider to prioritise children's immunisations and the practice offered dedicated clinics for immunisations on Wednesdays and Fridays to try to improve uptake.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	33.8%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	46.3%	55.7%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	49.8%	57.0%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	50.0%	50.3%	55.4%	No statistical variation

Any additional evidence or comments
<p>The provider was aware they were significantly below the target for cervical cancer screening.</p> <p>The practice had appropriate systems in place to re-call patients and monitor cervical cancer screening samples, to ensure that a result was received for every sample.</p> <p>At the time of the inspection, the practice had one nurse who had been approved to take samples, a second nurse was undergoing training. Following the inspection, the practice told us the second nurse had completed their training and was also able to take samples.</p> <p>We found however, the practice did not have a system in place to monitor those patients that had been referred for further investigation (colposcopy). We checked three records and found there was no letter on those patient's records and the practice could not demonstrate if these patients had received an appointment for the procedure.</p> <p>Following the inspection, the provider told us they had now implemented a process for the monitoring of patients referred for colposcopy and they had contacted all relevant patients to enquire if they had received their appointment.</p>

Monitoring care and treatment

The practice was able to demonstrate there had been some quality improvement activity to review the effectiveness and appropriateness of the care provided.

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

The practice had clinical leads for monitoring different clinical areas, called focus groups. They monitored activity for the practice for that area and shared performance information with the lead GP. Staff we spoke with told us they had met in June 2022 to discuss performance. From the provider's governance system we saw there were minutes for the meeting, however, there were no details of performance within the minutes for us to view.

Following the inspection, the provider told us the meeting minutes were available, however, they were not provided.

The practice shared evidence of clinical audits. The practice had carried out an audit in February 2022 of their prescribing of an antibiotic used to treat acne.

- The audit included 47 patients in the audit and showed the practice was not always meeting national standards for example 18 out of 47 patients (38%) were followed up within 12 weeks of being prescribed antibiotics. The standard is that all patients should be followed up within 12 weeks.
- 45 out of 47 patients (96%) who were prescribed oral antibiotics for acne were also prescribed topical acne treatment. The standard is that all patients should be prescribed topical treatment.
- Of the 38 female patients who were prescribed oral antibiotics for acne, six patients (16%) were advised regarding long term side effects. The standard is that all female patients should be advised about long term effects.

The practice had formed an action plan, and planned on repeating the audit in 12 months time.

Another audit in April 2021 looked at whether patients prescribed hormone treatment, were monitored at initiation and then on an ongoing basis as requested by the specialist service. The audit included 10 patients and showed seven out of 10 patients received the required monitoring. The practice had formed an action plan, this included repeating the audit in 12 months time. The practice did not provide evidence of a repeat audit.

Effective staffing

The practice was not fully 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.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Partial
There was an induction programme for new staff.	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.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The provider had improved their systems to monitor staff training, and we found that all staff had completed training required by the provider, that had been assigned to them.</p> <p>We saw that new starters had time allocated to complete required training.</p> <p>We saw from practice meeting minutes, staff were advised to complete mandatory training, and they were told they could claim overtime, if they didn't have time during work hours. We found evidence that staff had completed training in their own time. This would indicate that not all staff had protected time during working hours to complete training required by the provider.</p> <p>We found that 12 staff (of 20, not including new starters) had received appraisals, we saw evidence to indicate that dates had been arranged for those appraisals that still needed completing.</p> <p>The provider was using an external company to support with recruitment and HR issues. However, staff we spoke with told us when concerns about staff performance were reported to the management team, their concerns were not listened to.</p> <p>Following the inspection, the provider told us they had, in response to staff concerns, implemented a specific incident form that could be completed when staff performance was an issue. A meeting would be held with relevant staff members and information placed in personnel files for monitoring.</p> <p>The provider did not have formal clinical supervision in place for all non-medical prescribers and could not provide evidence of prescribing qualifications.</p> <p>Following the inspection, the provider sent us evidence of non-medical prescriber's qualifications.</p>	

Coordinating care and treatment

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

Indicator	Y/N/Partial
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
Explanation of any answers and additional evidence:	

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 and tackling obesity.	Yes
Explanation of any answers and additional evidence:	

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
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence:	

Well-led

Rating: Requires improvement

At the inspection in November 2021 we rated the practice as Inadequate for providing well-led services as the leadership team were unable to demonstrate they had the skills or capacity to deliver quality sustainable care and monitor governance processes effectively.

Following this inspection, the practice is rated requires improvement for providing well-led services. The provider had taken action to improve governance processes, however, we found not all processes were fully embedded or effective.

Leadership capacity and capability

Leaders could not demonstrate there was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: Following the previous inspection in November 2021, the provider had sought support from the clinical commissioning group and an external recruitment company to improve systems and processes to become compliant with regulations. At this inspection, we found the provider had improved governance and safety processes however the management team could not demonstrate they were effectively managing all aspects of the practice. We spoke with five clinical and five non-clinical staff during the inspection. Some staff we spoke with told us that the management team did not always listen to their concerns about risk and performance, and the management team did not always respond to tasks or emails, so staff didn't know if their request had been actioned. They also told us the management team were not always visible and so it was difficult to receive effective guidance and support when it was needed. Following the inspection, the provider told us a member of the management team was always on site.	

Vision and strategy

The provider had produced a vision and set of values but were not able to demonstrate how their strategy was monitored.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	No

Staff knew and understood the vision, values and strategy and their role in achieving them.	No
Progress against delivery of the strategy was monitored.	No
<p>Explanation of any answers and additional evidence:</p> <p>Following the previous inspection, the provider had produced a vision, a set of values and a business plan.</p> <p>Our Vision : To be the best urban GP practice for young professionals and students</p> <p>Our Mission : To provide a holistic and comprehensive GP service for those patients living in Birmingham City Centre</p> <p>Our Aims: To provide good access of primary care team and health education for patients living in Birmingham City Centre</p> <p>Our Values: Easy access and holistic total health care for patients with an emphasis in self-care</p> <p>Not all staff we spoke with were aware of the practice vision and values.</p> <p>The provider had implemented governance meetings to discuss performance and the business plan. We saw there had been a meeting on 28 June 2022, however, minutes of the meeting had no detail. Following the inspection, the provider told us the meeting minutes were available, however, they were not provided.</p>	

Culture

The practice culture did not effectively support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial
Staff reported that they felt able to raise concerns without fear of retribution.	No
There was a strong emphasis on the safety and well-being of staff.	Partial
There were systems to ensure compliance with the requirements of the duty of candour.	No
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	No
The practice encouraged candour, openness and honesty.	Partial
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The provider was using an external company to assist in recruitment and staff performance issues. However, some staff we spoke with told us that when they reported concerns about other staff's behaviour, their concerns were not being listened to and it was impacting patient care. During the inspection, we found evidence to support their concerns.</p> <p>We found some staff still felt they were not well supported. We were told there was limited leadership and support available. For example, during staff sickness or shortages, we were told management did not lead on delegating work out to others.</p> <p>We spoke with five clinical and five non-clinical staff, we found a divided culture amongst them. Some staff felt there had been improvement since the last inspection, others felt that although there had been improvements in terms of policies for them to follow, they hadn't been given the time to familiarise themselves with the policies, and any changes implemented since the previous inspection were not having a positive impact on their workloads.</p> <p>Staff told us they couldn't always speak up about concerns they may have, for fear of repercussions.</p> <p>The provider told us they encouraged staff to speak up and meetings and daily huddles had been introduced to discuss immediate risks</p> <p>We were told there had been five significant events since the last inspection, however we were not provided with any evidence of these events or discussions of them during meetings and the provider could not demonstrate they had systems to ensure compliance with the requirements of the duty of candour.</p>	

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

Source	Feedback
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Staff we spoke with	<p>Mixed feedback. Some staff felt there had been improvements however were not able to give us specific examples of how the service had improved. Other staff said that there was a lack of leadership, the management team were not always available for support.</p> <p>Some staff were concerned about speaking up and when they did, they felt they weren't being listened to.</p>
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Governance arrangements

The provider had improved governance arrangements.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Following the previous inspection, the provider had improved their governance systems and processes.</p> <p>We found staff were much clearer on their roles and responsibilities.</p> <p>The practice was using an IT system to help them monitor when risk assessments were due, the same system was used to monitor staff training and share information such as policies.</p> <p>The provider had introduced meetings to discuss governance, however we did not see evidence of what was discussed.</p> <p>Following the inspection, the provider told us the meeting minutes were available, however, they were not provided.</p>	

Managing risks, issues and performance

The provider had improved 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.	Partial
There was a quality improvement programme in place.	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.	Partial
Explanation of any answers and additional evidence:	
<p>The provider told us they had introduced quarterly governance meetings however we did not see evidence of the discussions that had taken place.</p> <p>The provider had improved systems and processes to help identify, understand, monitor and address current and future risks including risks to patient safety. However, we found not all systems were fully embedded or effective. For example, systems to manage workload, staff sickness, Patient Group Directives, and clinical supervision of non-medical prescribers.</p>	

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes

Staff were supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence: The provider had improved processes to deal with backlogs in records that needed returning once patients de-registered with the practice.	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence:	
We were told there had been a governance meeting in June 2022 to review performance, however there was no detail in the minutes to demonstrate what had been discussed.	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
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
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.	N/A
The practice advised patients on how to protect their online information.	Yes
Explanation of any answers and additional evidence:	
At the time of the inspection, the practice were not offering online consultations.	

Engagement with patients, the public, staff and external partners

There was some evidence 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.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence:	
<p>We saw meeting minutes for June 2022, where the practice had met with the Patient Participation Group (PPG). From minutes, we saw that the group were provided with staffing updates and patients were given the opportunity to ask questions.</p> <p>We did ask to speak with a representative from the PPG as part of the inspection process, however, the provider did not make the necessary arrangements.</p> <p>The provider had carried out a staff survey in June 2022. Evidence we viewed showed approximately half of the workforce completed the survey. Where feedback was negative, the provider had formed an action plan. Actions were due to be completed by September 2022.</p> <p>The practice had carried out a patient survey to gather patient feedback. Following the survey, the provider decided they would amend how far in advance patients could pre-book appointments (from two to three weeks) to improve access.</p>	

Feedback from Patient Participation Group.

Feedback
We did not speak with the PPG during the inspection.

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.	Partial
Explanation of any answers and additional evidence:	
<p>The provider had made improvements and taken relevant action following the warning notice we issued after the November 2021 inspection.</p>	

Although we saw evidence of clinical audits, many of these were one cycle audits and there was limited evidence to show improvements in quality of care.

We found some evidence of learning following significant events, however there was no evidence to demonstrate sharing of information or learning following more recent events (November 2021 to June 2022).

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.
- **UKHSA:** UK Health and Security Agency.
- **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.
- ‰ = per thousand.