Care Quality Commission

Inspection Evidence Table

Vine Medical Group (1-566292747)

Inspection date: 14 and 15 November 2018

Date of data download: 08 November 2018

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

Safe

Safety systems and processes

Safeguarding	Y/N
There were lead members of staff for safeguarding processes and procedures.	Yes
Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Policies were in place covering adult and child safeguarding.	Yes
Policies were updated and reviewed and accessible to all staff.	Yes
Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs)	Partial
Information about patients at risk was shared with other agencies in a timely way.	Yes
Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients	Yes
Disclosure and Barring Service checks were undertaken where required	Partial

Explanation of any 'No' answers:
The practice confirmed they had lead members of staff for safeguarding. These individuals were identified in the practice's policies for safeguarding children and vulnerable adults. However, not all staff were correct when asked to identify who the practice safeguarding lead was. Of the 12 staff face-to-face interviews we undertook during the inspection, we asked seven members of staff who they're safeguarding lead was, and of those seven, six answered correctly. We also received 15 completed staff questionnaires which contained a question to identify the practice's safeguarding lead. Of those 15 completed questionnaires, 13 were correct and a further one was partially correct.

We were informed during the inspection that any changes to systems, processes and practices were implemented and communicated to staff via 'The Tree'. The Tree was identified as the practice's intranet / networking system which all staff could access from any computer across all sites at the practice. The Tree had been specifically designed, created and implemented by Vine Medical Group to support staff in accessing all the information that they required to complete their day to day roles. Throughout the inspection, when asked, staff would confirm they would access 'The Tree' to find policies, pathways and protocols. The Tree was also used to identify which site staff were working at on a specific day as many of the staff worked across a variety of sites on different days.

We were provided with copies of the practice's safeguarding children and vulnerable adults policies. On review of the policies, we found the safeguarding children policy was due a review in November 2018, while the vulnerable adults policy was overdue a review. This review had been documented on the policy to have been undertaken in April 2017.
Since inspection, the practice has provided evidence that confirmed the vulnerable adults policy was in fact reviewed on 11 November 2018 but the policy itself was not updated with a new review date. This was identified as a clerical error.

The practice policy expected Level 1 safeguarding children's training to be completed by all staff on induction and then updated annually by clinical staff, while Level 2 training was to be completed every three years. For safeguarding adults training, the practice expected Level 1 training to be completed by all staff every three years; Level 2 was also expected for nurses every three years. The safeguarding children's policy stated GPs were required to complete Level 2 training and only the practice's safeguarding lead required Level 3 training. The policy was not in line with the National Intercollegiate guidance for the safeguarding of children, which states clinical staff who work with children, young people and their parents and carers complete Level 3 training. The vulnerable adults' policy did not contain information about the expected frequency for staff to complete safeguarding adults training.

Since inspection the practice has provided a revised training requirement checklist for all staff, particularly in relation to safeguarding children and adults training. This was in line with the Intercollegiate guidance.

A staff training log provided by the practice demonstrated safeguarding children and adult training had not been consistently completed in line with their own policies. For example:

- All seven members of the prescribing team had completed both safeguarding modules in the previous 12 months.
- Of the seven healthcare assistants at the practice, five had completed safeguarding children training within the previous 12 months, and four had completed safeguarding adults training within the same period.
- For the 21 practice nurses, nurse practitioners and paramedic practitioners at the practice, a variety of levels in relation to safeguarding children training had been completed in the previous two years. For example, five had a record of completing Level 1 training in the last 12 months, a further six had a record of completing Level 2 training in the previous two years, while 12 had completed Level 3 in the same period. Out of the 21, nine had completed safeguarding adults training within the same period. A further two, had no record of completing any safeguarding adults training. Two members of the nursing and paramedic practitioner team were identified as being on long-term absence from the practice.
- Of the 16 GPs employed at the practice, including partners and salaried GPs, two GPs were recorded as only completing either Level 1 or Level 2 safeguarding children training. Of the remaining 14, a record of level 3 training had been recorded for all 14 from the previous two-year period. In relation to safeguarding adults training, seven of the 16 GPs had completed Level 3 training in the previous 12 months.
- Since inspection, the practice has confirmed all 16 GPs have completed Level 3 safeguarding training for children and adults within the last three years.
- Of the 24 call handlers, including mentors, based within the practice's hub, 12 had completed safeguarding training in the previous 12 months. Six had no record of completing any form of safeguarding children training. In relation to safeguarding adults training, 11 had completed the training in the previous 12 months. Eight had no record of completing any form of safeguarding adults training. Two members of the call handling team were identified as being on long-term absence from the practice.

- Of the combined non-clinical staff, totalling 35 individuals, 21 had a completed record of safeguarding children training from the previous 12 months, while a further four individuals had no record at all. In relation to safeguarding adults, 19 out of 35 non-clinical staff had a completed record from the previous 12 months, and the same four individuals had no record at all. Two non-clinical staff members were identified as being on long-term absence from the practice.

Since inspection, the practice has provided an updated training log and in view of the practice's updated training policy for safeguarding training to be completed three-yearly, more staff have been identified as compliant with safeguarding training recommendations. The training log provided evidence that staff had completed an update on safeguarding since the inspection, but there was still evidence of one staff member being overdue their recommended update in safeguarding.

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

Explanation of any answers:

The practice confirmed they routinely used the services of an independent recruitment consultant when recruiting new staff. The practice reported the recruitment consultant completed an initial telephone interview with applicants. This was followed by a formal interview on site with practice management staff. The practice told us non-clinical staff applicants were encouraged to complete a half-day shadowing experience of the role they were applying for to ensure they are aware of the demands of role prior to confirming employment.

On review of the practice's staff log, of the 110-staff employed by Vine Medical Group, we saw:

- 43 staff members had a record of a completed Disclosure and Barring Service (DBS) check. We noted four of those staff members had no record of the certificate serial number.
- 57 staff members had been risk assessed by the practice to not require a DBS certificate. We saw evidence of these risk assessments and found them to be appropriate.
- A further four staff members were documented as either having reapplied for a DBS certificate, or had been identified as requiring one but no confirmation of applying for a DBS check had been recorded.

Since inspection, the practice has provided an update on staff members' DBS checks, including evidence of three members of staff applying for either an initial DBS check or a DBS 'recheck' dated 11 January 2019.

We saw evidence of medical indemnity insurance in place for all staff who required it, including GPs, nurses, paramedic practitioners, pharmacists and healthcare assistants.

Safety Records	Y/N
There was a record of portable appliance testing or visual inspection by a competent person Date of last inspection/Test: August 2016.	Yes
There was a record of equipment calibration Date of last calibration: 13 February 2018.	Yes
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	Yes
Fire procedure in place	Yes
Fire extinguisher checks	Yes
Fire drills and logs	Yes
Fire alarm checks	Yes
Fire training for staff	Yes
Fire marshals	Yes
Fire risk assessment Date of completion: 25 October 2018 at the Stakes Lodge site.	Yes
Actions were identified and completed. No actions were identified in the fire risk assessment undertaken at the Stakes Lodge site on 25 October 2018. The fire risk assessment confirmed that emergency lighting and automatic fire detection system had been tested in the previous four weeks.	
Additional observations: We were told by the Operations Manager that a fire risk assessment was completed monthly at every site within the Vine Medical Group organisation. We were provided with evidence of the monthly fire risk assessments undertaken at the Stakes Lodge site, dating back to April 2018.	
Health and safety Premises/security risk assessment? Date of last assessment: September 2018	Yes
Health and safety risk assessment and actions Date of last assessment: 26 & 27 September 2018	Yes

Additional comments:

The provider has a protocol in place for portable appliance testing (PAT). PAT checks were scheduled to take place every 36 months. The practice confirmed the next PAT was due in August 2019.

Equipment calibration checks were undertaken every year. The practice provided evidence of multiple certificates as evidence of equipment calibration checks from across all four sites.

We saw the last fire drill took place at the Stakes Lodge on 9 November 2018. The fire drill identified the visitor log and additional resources had not been collected in line with fire warden responsibilities.
We saw evidence of a log recording all fire alarm checks undertaken weekly at the Stakes Lodge site.

The practice had delegated all health and safety responsibilities to an Operations Manager who had full oversight of all four sites. The Operations Manager also had full oversight of the practice's maintenance log, or fault log. Staff could log any issue or report a fault on The Tree. The fault log was reviewed by the Operations Manager and prioritised accordingly. For example, an electrical or gas failure would take higher priority than a request to install an information board at one site. Any faults or issues relating to a building or site was overseen by the Operations Manager, any issues relating to IT or computer systems was overseen by the practice's IT lead. One example of a reported fault was from 13 November 2018, for a window that was sticking during opening. This issue had already been raised and resolved previously so the Operations Manager was planning to contact an external contractor to have it assessed properly.

We saw evidence of a variety of risk assessments completed by the practice. For example:

- Legionella risk assessment, dated 26 October 2017. The risk assessment identified that the practice was only doing annual water temperature checks as part of their Legionella actions. This had been identified as 'Outdated Practice'. The risk assessment identified the practice were undertaking 'outdated' practice in a further 10 out of 84 indicators. We were not able to ascertain if these 'outdated' practices had been assessed and rectified. The remaining 74 indicators were assessed to be carried out using conventional, good or best practice in line with national guidance.
- A risk assessment was completed following a complete power failure at the Forest End site on 3 November 2017. Despite having emergency lighting in place, the power failure identified the need for additional lighting to aid patient and staff evacuation. The risk assessment confirmed battery-power lanterns had been purchased and were now available at all four sites.
- Risk assessments have been completed for patient waiting areas, administration rooms, the practice's new automatic doors at Forest End site and the lift, used by staff and patients, at Stakes Lodge.

We saw evidence of completed water sample checks for three of the four sites, dated January 2018.

Infection control	Y/N
Risk assessment and policy in place	Yes
Date of last infection control audit: Ongoing.	
The practice acted on any issues identified	Yes
Detail: We reviewed the practice's ongoing infection prevention and control audit that had been implemented since 2017. The practice reviewed each of the four sites and created an action plan for each site. For example, • At Stakes Lodge, of the 42 identified actions throughout the whole site, 35 had been completed. The remaining seven actions were outstanding as they required additional resources to be completed. For example, the ordering of a new curtain track in one of the consultation rooms. • At Forest End, of the 60 identified actions throughout the whole site, 43 had been completed. The remaining 17 actions were outstanding as they required additional resources to be completed. For example, the ordering of wipeable patient chairs in each of the consultation rooms. • At Westbrook, of the 16 identified actions throughout the whole site, 12 had been completed. The four actions remained outstanding as they required additional	

resources to be completed. For example, the ordering of wall-mounted soap and hand-sanitizer dispensers. • At the Health Centre, of the 42 identified actions throughout the whole site, 13 had been completed. Additional actions had been referred to the practice's cleaners due to dirt and dust being identified as visible on skirting boards throughout the site. Our own visual inspection during our visit demonstrated that the Health Centre site was clean and generally dust-free.	
The arrangements for managing waste and clinical specimens kept people safe?	Yes

Explanation of any answers:

We found the practice was not consistent in the security of their external clinical waste storage bins. For example:

- At the Stakes Lodge site, the external clinical waste bins were locked and secured to the premises building.
- At the Forest End site, the two external clinical waste bins were locked but not secured to anything. The practice has since confirmed contractors have been contacted to add additional security to the bins at this site.
- At the Westbrook site, the external clinical waste bin was in the top corner of car park, locked but not secured to anything. The practice has since confirmed contractors have been contacted to add additional security to the bin at this site.
- At the Health Centre site, we did not review the security of the external bins. The practice provided assurance that these bins were securely stored inside an external locked compound.

The practice had identified two members of staff who acted as the infection prevention and control (IP&C) leads across all four sites. They provided us with evidence of daily cleaning checks that all staff were expected to contribute to. We saw a total of seven daily cleaning tasks check lists. Each site held a number of these checklists, depending on how many rooms each site had. Staff were expected to complete these cleaning tasks, and sign once completed, daily.

We saw evidence of an IP&C newsletter that the practice released on a six-monthly basis. It contained information such as the introduction and location of new infection control boxes and spillage kits at all four sites, direction to The Tree for staff to access new infection control policies and a new number for the reporting of needlestick injuries.

The practice reported two occasions where they had notified Public Health England about infectious incidents in line with national guidance.

IP&C training was recommended by the practice's own IP&C policy to be completed on an annual basis for all staff. However, this was different to the practice's recommended training schedule which stated non-clinical staff were required to complete IP&C level 1 training every two years. On review of the practice's training log provided during the inspection, we found of the total 110 staff at the practice, 70 staff had completed IP&C training within the previous 12 months. A further 29 had completed IP&C in the previous two years, and the remaining 11 staff members had no record of completing IP&C training previously.

The practice provided us with a copy of their 'Infection Control Annual Training Pack for nurse practitioners, practice nurses, paramedics, HCA and GP'. This pack was intended to support clinical staff in 'mandatory education/annual update'. The pack contained information, activities and guidance covering the basic principles of all areas of infection prevention and control within primary care.

Risks to patients

Question	Y/N
There was an effective approach to managing staff absences and busy periods.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans were developed in line with national guidance.	Yes
Staff knew how to respond to emergency situations.	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
In addition, there was a process in the practice for urgent clinician review of such patients.	Yes
The practice had equipment available to enable assessment of patients with presumed sepsis.	Yes
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Yes.

Explanation of any answers:

The practice had a designated team who assessed and arranged the staff rotas for the entire practice, across all four sites. On discussion with the team, they confirmed they were planning and assessing rota arrangements into January 2019. They confirmed regular informal meetings were held with clinical leads to discuss any issues with regards to staffing, well in advance, to ensure appropriate staff cover was in place.

We saw evidence of appropriate protocols accessible via The Tree that covered many aspects of clinical issues which patients may contact the practice about. We reviewed the protocols and found evidence of appropriate protocols that covered symptoms from sepsis and chest pain to ear symptoms and asthma. All protocols were in line with national guidance.

The practice's hub was based at the Health Centre site, alongside the practice's Same Day Care Team (SDCT). All incoming calls regarding a medical issue was directed to the hub, where a call handler would answer the call. Each call handler had access to a call mentor and a duty GP. Access to clinical support was available at all times. Using the protocols from The Tree, a call handler would either signpost a patient or transfer the patient to the Duty GP. We received assurances from the practice that no clinical call from a patient ended with a call handler providing the final advice.

During our inspection, we were informed of an emergency that took place at the Health Centre. The patient was successfully transferred to the local hospital for further treatment. We were told a significant incident form had already been raised to learn from the incident, as it been identified a new protocol regarding shortness of breath was required and a different sized face mask was required in the emergency equipment bag.

Information to deliver safe care and treatment

Question	Y/N
Individual care records, including clinical data, were written and managed in line with	Yes

current guidance and relevant legislation.	
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented.	Yes
The practice had a documented approach to the management of test results and this was managed in a timely manner.	Yes
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes

Explanation of any answers:

We found there were few test results awaiting review by a clinician. All results remaining being dealt with appropriately.

There was a 'buddy system' in place when clinicians were on leave or away from the practice due to sickness. However, during first day of inspection, we found no cover was in place for monitoring the test results ordered by staff who were routinely absent from practice due to their confirmed working patterns. This was raised with the practice and was addressed in time for our return on the second day of inspection. A new notice had sent via The Tree to all staff to confirm a buddy cover system had been devised to ensure the test results of those clinicians who were absent due to work patterns had been implemented.

Appropriate and safe use of medicines

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) (01/07/2017 to 30/06/2018) NHS Business Service Authority - NHSBSA)	0.79	0.90	0.95	Comparable with other practices
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). (01/07/2017 to 30/06/2018) (NHSBSA)	7.1%	8.8%	8.7%	Comparable with other practices

Medicines Management	Y/N
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
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Yes
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, audits for 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 systems for the safe ordering, checks on receipt, storage, administration, balance checks and disposal of these medicines in line with national guidance.	N/A
Up to date local prescribing guidelines were in use.	Yes
Clinical staff were able to access a local microbiologist for advice.	Yes
For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance.	Yes
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	Partial
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Yes
There was medical oxygen on site.	Yes
The practice had a defibrillator.	Yes
Both were checked regularly and this was recorded.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Yes

Explanation of any answers:

We reviewed the practice's process for monitoring the security of blank prescription stationery across all four sites. We were told boxes of blank prescription stationery were received and logged on arrival at one identified site. These boxes were securely stored away from the clinical areas. When another site required a new box, this was removed from its central holding point, logged as removed and its intended destination, but no date of the removal was recorded. The practice told us they did not record serial numbers of blank scripts when stationery was removed to be used at any site. The practice confirmed the printers were all emptied at the end of each day, and the unused blank stationery was returned to a secure cupboard but serial numbers were again not being logged. We raised this with the practice during the inspection who told us they would be able to locate a box of stationery, but could not identify the individual room or clinical prescriber that a batch of prescription stationery had been assigned to. This was in not line with national guidance.

Since inspection, the practice has provided evidence of a new protocol that ensures the monitoring of blank prescription stationery in line with national guidance. We received assurances from the practice that the new protocol was effective immediately.

The process for the management of high risk medicines, including methotrexate and lithium was monitoring by the prescription team, led by two pharmacists. Evidence of an audit regarding Methotrexate was provided by the practice and demonstrated that the initiation of shared care protocols had improved. But further improvements were required to maintain patient safety when taking high-risk medicines. For example, six patients out of a total of 24 receiving Lithium, approximately 25%, had no record of an up to date blood test.

We saw no evidence of non-medical prescribing being monitored. The practice was invited to provide this information after the inspection, but we did not receive any further information regarding non-medical prescribing monitoring.

Since inspection, the practice has confirmed one paramedic was undertaking their prescribing qualification while all other paramedics were not yet able to prescribe. To support their remaining non-medical prescribing practitioners, for example, advanced nurse practitioners, the practice has additional information. This included an audit on the non-medical prescribing rates and minutes from meetings starting from April 2018 which demonstrated the practice were monitoring non-medical prescribing appropriately.

We reviewed the emergency medicines and equipment at all four sites of the practice. Our findings were as follows:

- At Stakes Lodge, all emergency equipment and a selection of the emergency medicines were stored in an unlocked cupboard for ready access along the treatment corridor. The door of the cupboard was marked 'Keep Locked' but we were informed that this was an old sign and needed to be removed. We saw evidence of the equipment being checked monthly and all equipment was seen to be in date. The emergency 'grab bag' contained a selection of emergency medicines, such as Adrenaline, Chlorphenamine and Glyceryl trinitrate spray. The remaining recommended emergency medicines were stored in a locked cupboard with an associated key-safe, in a nearby treatment room. No opiates were in the emergency medicines stock but we found other pain-relieving medicines instead.
- At Forest End, we saw evidence of the emergency equipment and emergency medicines being checked monthly, all were in date. No opiates were in the emergency medicines stock but we found other pain-relieving medicines instead.
- At Westbrook, we found evidence of emergency medicines in a 'grab bag' and in an unlocked cupboard in a treatment room. The emergency medicines were locked away each day in a different area where a lockable cupboard was located. We saw evidence of the emergency medicines and equipment being checked monthly. The emergency medicines stock did not contain any anti-epileptic medicines, Salbutamol, opiates, Naloxone or Dexamethasone. We received assurances these medicines were not stocked at Westbrook with the approval of the lead GP but no formal risk assessment had been created to document these decisions.
- The defibrillator at Westbrook was reported to an 'old' model. The practice was aware that their paediatric pads had expired as of 8 November 2018 but had been unable to source a replacement due to the age of the defibrillator model. We were told practice leaders were aware of this but we saw no evidence of a risk assessment or alternative measures having been put in place to address this issue.
- At the Health Centre, the emergency medicines and equipment were checked monthly but also visually checked daily and re-stocked if any items had been used. The emergency medicines did not contain opiates due to the practice not stocking controlled drugs, however, we did not see evidence of a risk assessment that formally recorded this decision.

Track record on safety and lessons learned and improvements made

Significant events	Y/N
There was a system for recording and acting on significant events	Yes
Staff understood how to 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.	32

Number of events that required action	32

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

Event	Specific action taken
Patient attended the practice with central chest pain.	Reception staff activated the emergency button and clinical staff responded with an appropriate emergency procedure. The reception team called for an ambulance. Patient was successfully transferred to the local hospital and received further emergency treatment on arrival at hospital.
The practice was notified that a patient record had been accessed without appropriate cause by a member of non-clinical staff.	Incident was investigated by senior leaders and the received information was found to be factual. The identified staff member was interviewed and dismissed from all future employment at the practice in line with their confidentiality policy. Practice informed the Local Medical Council and defence organisation of the breach of confidentiality. The affected patient was informed, apologised to and invited to the practice for further discussion of the incident. Staff were reminded of their duty of confidentiality and information governance. Practice confirmed they continued to audit staff access to records.
A generic email inbox, previously thought to have been de-activated following one of the practice's mergers, was found to still be active and contented over 7,400 unread documents.	Items from the unmonitored inbox were identified to be mainly Emergency Department discharge summaries. The practice authorised staff to be paid overtime so all documents could be timely reviewed. Of the 7,400 original documents, 330 discharge summaries required a GP review. The practice found that no identifiable harm was identified among those 330 documents arising from a failure to read their discharge summaries. The practice had implemented a new monitoring system for all practice inboxes. They have also started to explore ways of monitoring the quantities of correspondence from other departments.

Safety Alerts	Y/N
There was a system for recording and acting on safety alerts	Yes
Staff understand how to deal with alerts	Yes

Comments on systems in place:

All safety and medicines alerts were received by the Operations Manager. Alerts were added to the practice's intranet and a notification sent to the relevant clinicians to inform them of the alert. Clinicians actioned the alert and reported back to the Operations Manager once the alert has been actioned. The alert and actions were stored together on The Tree. The Operations Manager confirmed The Tree monitored who accessed new notifications and staff members were chased if it was noted they had not accessed or read new posts.

We were provided with a copy of the practice's protocol in dealing with alerts. Initially the protocol only contained information about medicines alerts; we raised this with the practice and by the second day of inspection, the protocol had been amended to include all alerts.

Any additional evidence
The practice told us they were one of the first local practices to pilot and develop the local clinical commissioning group's online reporting resource for significant events and complaints. The resource, called QUASAR, was designed to collate data and provide reports on rates of complaints, and summarises risk data for practices to learn from. QUASAR was designed to help identify specific areas of concern for practices to concentrate their own learning on. The practice told us they reviewed significant events every two months. At least one member of every team at the practice was required to attend these meetings. Each significant event was reviewed and RAG-rated for severity. We were told minutes that were taken at those meetings, including any identified learning points, were then shared on The Tree for all staff to access. We were told by the practice that The Tree monitored when staff had read new posts and staff would be reminded to access any notifications if they had not done so in a timely manner. Any new posts were archived once staff members had read them but remained accessible for future reference as required. We saw a selection of minutes from significant events review meetings which demonstrated that key learning points were being recorded for staff to access.

Effective

Effective needs assessment, care and treatment

Prescribing				
Indicator	**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) (01/07/2017 to 30/06/2018) (NHSBSA)	0.68	0.77	0.83	Comparable with other practices

People with long-term conditions

Diabetes Indicators				
Indicator	**Practice performance**	**CCG average**	**England average**	**England comparison**
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	84.4%	82.6%	78.8%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	14.2% (257)	16.8%	13.2%	
Indicator	**Practice performance**	**CCG average**	**England average**	**England comparison**
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	86.5%	82.5%	77.7%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	7.1% (128)	8.2%	9.8%	

Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	80.0%	79.4%	80.1%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	16.2% (292)	14.9%	13.5%	

Other long term conditions				
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	73.8%	76.5%	76.0%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	2.3% (44)	7.6%	7.7%	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	91.2%	92.1%	89.7%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	15.7% (102)	10.8%	11.5%	

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	87.9%	82.9%	82.6%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	2.6% (112)	3.7%	4.2%	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	83.1%	88.3%	90.0%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	6.5% (38)	7.7%	6.7%	

Families, children and young people

Child Immunisation				
Indicator	**Numerator**	**Denominator**	**Practice %**	**Comparison to WHO target**
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2016 to 31/03/2017)(NHS England)	294	300	98.0%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2016 to 31/03/2017) (NHS England)	267	285	93.7%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2016 to 31/03/2017) (NHS England)	267	285	93.7%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2016 to 31/03/2017) (NHS England)	267	285	93.7%	Met 90% minimum (no variation)

Working age people (including those recently retired and students)

Cancer Indicators				
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2016 to 31/03/2017) (Public Health England)	75.6%	75.5%	72.1%	Comparable with other practices
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) **(PHE)**	74.0%	73.4%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)**(PHE)**	61.8%	62.1%	54.6%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. **(PHE)**	79.4%	78.8%	71.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE)	54.0%	48.2%	51.6%	Comparable with other practices

Any additional evidence or comments

The nursing team at the practice were aware they had not achieved the national target for cervical screening of 80%. The nurses confirmed appointments with a practice nurse for cervical screening were available at any time of the day so that eligible patients had a better choice of appointments to suit their own availability. The nurses confirmed patients who had missed a planned appointment for a cervical screening were contacted by telephone to rebook. The practice attempted to increase uptake by issuing cervical screening appointment letters on pink paper and linked practice promotion advertising with national cervical screening awareness weeks.

People experiencing poor mental health (including people with dementia)

Mental Health Indicators				
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	96.9%	93.5%	89.5%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	8.5% (18)	10.3%	12.7%	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	92.9%	92.8%	90.0%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	7.5% (16)	9.1%	10.5%	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	78.0%	84.1%	83.0%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	3.9% (11)	4.5%	6.6%	

Monitoring care and treatment

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	-	-	-
Overall QOF exception reporting (all domains)	5.4%	5.6%	5.8%

Coordinating care and treatment

Indicator	Y/N
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Yes

Helping patients to live healthier lives

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	96.9%	94.9%	95.1%	Comparable with other practices
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	1.2% (88)	0.6%	0.8%	

Consent to care and treatment

Description of how the practice monitors that consent is sought appropriately
The practice confirmed written and verbal consent was recorded as required. The practice's patient record system contained templates for consent to be recorded for specific procedures, for example cervical smears and immunisations. If a written consent form required a signature, this was obtained from the patient, scanned and added to the patient's electronic record.

Any additional evidence
The training log provided by the practice demonstrated that not all staff were up to date with all the practice's recommended training. • For fire safety training, which was expected to be completed two yearly, we saw evidence of 105 out of a total of 110 total staff members had completed the training module in the previous two years. • For basic life support training, which was expected to be completed annually, we saw evidence of 87 out of a total of 110 staff members who had completed the training module in the previous 12 months. • For information governance training, which was expected to be completed annually, we saw evidence of 83 out of a total of 110 staff who had completed the training module in the previous 12 months. • For equality and diversity training, which was expected to be completed three yearly, 106 out of a total of 110 staff members had a record of completed training in the previous three years.

- The practice did not include Mental Capacity Act 2005 training as part of their recommended training schedule.

Since inspection, the practice has provided an updated training log. The training records showed that some staff had completed their recommended training updates after our inspection but there was still evidence which demonstrated some staff were overdue an update in some training areas.

The practice confirmed staff appraisals were completed every 12 months for clinical staff and every 18 months for non-clinical staff. For new staff, the practice reported they completed staff reviews during the first month of employment, then again at three, six and twelve months. On review of the practice's training log we could see:

- Seven out of 16 GPs had a record of a completed appraisal in the previous 12 months.
- Four of the seven members of the prescribing team had a record of an appraisal. The three remaining staff members of that team had a date scheduled for late 2018/mid 2019 that corresponded to their employment start date.
- Out of 21 nurses, nurse practitioners and paramedic practitioners, we saw evidence of 12 appraisals which had been completed in the previous 12 months. An additional four staff members in that team were new staff members so were not yet due an appraisal.
- Out of the seven healthcare assistants, six had a record of an appraisal having been completed in the previous 12 months. The remaining healthcare assistant was a new member of staff so was not yet due an appraisal.
- Of the 59 non-clinical staff members, 56 had a record of an appraisal having been completed in the previous 18 months or had already been booked due to their recent start date.

Since inspection, the practice has confirmed all staff, apart from those on long-term absence from the practice, have received an appraisal in line with their own policy.

The practice provided evidence to demonstrated that an extensive mentoring support system was in place at the practice. We saw evidence of call handlers, paramedics, practice nurses, nurse practitioners and student nurses receiving peer or mentor supervision support sessions. The sessions were documented in a follow up a report which identified three learning points for each individual clinician or non-clinical staff member to work towards.

The practice had installed a 'podium' at the Health Centre which was staffed once a week by volunteers who were able to signpost patients to additional services that patients would be able to access. For the remaining days of the week, the podium was staffed by members of the practice staff who would be able to deal with practice queries.

The practice had devised and created their own Home Visiting Service since 1 September 2018. This was formulated with another local practice but staffed by Vine Medical Group. The Home Visiting Service allowed for patients to receive prompt home visits that could supplement quick transfer to hospital if required. The practice used evidence-based guidance that if a patient was seen at a local hospital quicker, some patients were more likely to be discharged home the same day rather than require a hospital admission.

Caring

Kindness, respect and compassion

CQC comments cards	
Total comments cards received	170
Number of CQC comments received which were positive about the service	114
Number of comments cards received which were mixed about the service	49
Number of CQC comments received which were negative about the service	7

Examples of feedback received:

Source	Feedback
CQC Comments cards, NHS Choices	Patients who completed positive comment cards said that staff at the practice were helpful, friendly and kind. Patients stated they felt looked after and were treated with respect when accessing the services at the practice. Cards that contained mixed comments about the service did not refer negatively to how patients were treated at the practice. The mixed comments referred to how patients were having to wait long periods of time for an appointment. Patients also stated the telephone system was an issue, for example, they struggled to get through when ringing the practice. Cards contained negative comments were in relation to accessing appointments in a timely manner, accessing the practice's telephone system, the cleanliness of the children's toys in the practice, and the time it took for a referral for specialist services to be actioned. The practice was rated three and half stars out of five on NHS Choices, based on 163 reviews, dating back to October 2017. Comments made by patients stated staff were accommodating, kind, professional and caring when they had accessed the services at the practice. Under the categorisation of 'Dignity and Respect' the practice scored four out of five stars, based on 159 reviews.

Any additional evidence
On review of the comment cards received for our inspection, we noted a significant number featured examples of the same hand-writing. On review of this matter with the practice, we discovered members of the practice's patient participation group had completed the comment cards in conversations with patients who were attending one of the practice's seasonal flu clinics. To ensure the validity of the comments, we contacted a selection of the patients via the telephone numbers provided on the comment cards. We found the comments had been accurately documented and reflected the patients' feelings as they had discussed at the time. The local branch of Healthwatch also supplied us with information gathered from their patient feedback tool, Care Opinion. Comments received were mixed in patients' response to accessing the practice's telephone system and the length of time patients had to wait for an appointment.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology has changed in 2018. This means that we cannot be sure whether the change in scores was due to the change in methodology, or was due to a genuine change in patient experience.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
26988	250	102	40.8%	0.38%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	82.1%	89.3%	89.0%	Comparable with other practices
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018)	76.2%	88.5%	87.4%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	84.2%	95.5%	95.6%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	61.9%	84.0%	83.8%	Variation (negative)

Any additional evidence or comments

The practice was aware of the results from the National GP Survey. We saw evidence of minutes from a Patient Participation Group (PPG) meeting in September 2018 where the results had been discussed with the PPG. It records that an action plan would be devised to create improvements that could be proposed and shared with the PPG for their input.

Since inspection, the practice confirmed they have experienced similar results previously when change, practice growth and new models of care have been introduced to patients. The practice felt the National GP Survey was undertaken during a period when the practice was struggling with their telephone systems which had led to general dissatisfaction with their patients.

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

Date of exercise	Summary of results
June 2018 – Key Patient Experience Survey	• 44% of respondents reported they could access the practice easily on the telephone. • 83% of respondents found the practice's receptionists helpful. • 30% of respondents reported they usually got to see or speak to their usual GP. • 46% of respondent reported a good experience in making an appointment.
September 2018 - Key Patient Experience Survey	• 24% of respondents reported they could access the practice easily on the telephone. • 79% of respondents found the practice's receptionists helpful. • 9% of respondents reported they usually got to see or speak to their usual GP. • 39% of respondent reported a good experience in making an appointment.
September 2018 – Telephone Survey	Call handlers at the practice's hub asked patients 'Have you found the telephone system easier today than before we change to our new phone system?'. A total of 652 patients were asked this questions at the end of a call to the practice. Of the total 652 patients asked, 610 advised they had. This represented approximately 94% of patients asked that they had experienced an improvement following the changes to the practice's telephone answering system.

Any additional evidence
The practice confirmed they tend to use internet-based 'Survey Monkey' resource for service specific feedback exercises. The practice provided us with an ongoing action plan that listed actions identified from patient feedback responses, dating back to June 2018. Of the 31 identified actions, 22 had already been completed, three remained in progress and the remaining six had not yet been started but the practice had plans to do so in 2019. Completed actions included attending the local summer fete to engage with patients, answer non-clinical concerns and queries, highlight the E-consult service adopted by the practice, and promote their new telephone system that had been recently installed.

Involvement in decisions about care and treatment

Examples of feedback received:

Source	Feedback
Comment cards, NHS Choices	Patients who completed positive comment cards reported they felt involved with their care and treatment. Patients reported clinicians listened to their needs and preferences; patients reported clinicians did more than was expected of them to achieve a good outcome of them. Patients who completed mixed comment cards stated delays in referrals to secondary care services had been frustrating but once chased these had been addressed by the practice promptly. The negative comments provided by patients included not feeling listened to or looked after, a prolonged delay in accessing an additional diagnostic screen had impacted on their day to day activities, and a repeated course of treatment had been unsuccessful for a prolonged period until a second opinion had been sourced from a senior clinician. Comments made by patients on NHS Choices stated they had been involved in their care, and treatment received was appropriate to their needs.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	86.3%	94.2%	93.5%	Comparable with other practices
Any additional evidence or comments				

Question	Y/N
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 easy read format.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified	The practice had identified 930 patients who were also carers, seven of whom had been identified as patients under the age of 18 years. This represented approximately 3% of the practice's patient population.
How the practice supports carers	The practice offered carers a seasonal flu vaccine. The waiting areas at all four sites displayed posters for carers regarding local support groups and a carer charity. Carers were also provided with a carers pack once they had been identified which contained information on local and national support groups.
How the practice supports recently bereaved patients	The practice confirmed that the GPs would write to the families of recently bereaved patients to offer support.

Any additional evidence

Privacy and dignity

Question	Y/N
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Yes

	Narrative
Arrangements to ensure confidentiality at the reception desk	All telephone calls coming in to the practice throughout the working hours of the practice were answered within the hub based at the Health Centre. At Stakes Lodge: the reception area was separated from the waiting area completely. Patients attend the reception desk on arrival through the front door of the premise and passed through an additional door to access the waiting room. The receptionists could monitor patients in the waiting area by use of a window between the two areas. At Forest End: we did not review the arrangements to ensure confidentiality at the reception desk at this site. Westbrook: the reception desk was situated in the waiting area due to the constraints of the premise design. Patients were asked to identify themselves by their date of birth rather than name. Westbrook did not open until 8.30am on a week day to allow staff half an hour each morning to make phone calls from the reception desk without being overheard by patients in the waiting area. Health Centre: we did not review the arrangements to ensure confidentiality at the reception desk at this site.

Question	Y/N
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

Responsive

Responding to and meeting people's needs

Stakes Lodge site Opening Times	
Day	**Time**
Monday	8.00am-6.30pm

Tuesday	8.00am-6.30pm
Wednesday	8.00am-6.30pm
Thursday	8.00am-6.30pm
Friday	8.00am-6.30pm

Forest End site Opening Times	
Day	**Time**
Monday	8.00am-6.30pm
Tuesday	8.00am-6.30pm
Wednesday	8.00am-6.30pm
Thursday	8.00am-6.30pm
Friday	8.00am-6.30pm

Westbrook site Opening Times	
Day	**Time**
Monday	8.30am-1.00pm
Tuesday	8.30am-1.00pm
Wednesday	8.30am-1.00pm
Thursday	8.30am-1.00pm
Friday	8.30am-1.00pm

Health Centre site Opening Times	
Day	**Time**
Monday	8.00am-6.30pm
Tuesday	8.00am-6.30pm
Wednesday	8.00am-6.30pm
Thursday	8.00am-6.30pm
Friday	8.00am-6.30pm

Extended hours at Forest End site opening only	
Mondays	6.30pm-7.30pm
Wednesday	7.20am-8.00am

Home visits	Y/N
The practice had a system to assess whether a home visit was clinically necessary	Yes

and the urgency of the need for medical attention	

If yes, describe how this was done
The practice confirmed all requests for a home visit were received and recorded. The Same Day Care Team (SDCT) contacted each patient and triaged the needs of the patients accordingly. The SDCT consisted of a Duty GP, nurse practitioners, paramedic practitioners and non-clinical call handlers. Any home visits were then undertaken by paramedic practitioners.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
26988	250	102	40.8%	0.38%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	91.2%	96.0%	94.8%	Comparable with other practices
Any additional evidence or comments				

Timely access to the service

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	24.3%	71.7%	70.3%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	38.7%	70.7%	68.6%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	34.0%	64.3%	65.9%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	60.1%	78.7%	74.4%	Comparable with other practices

Indicator	Practice	CCG average	England average	England comparison
Any additional evidence or comments The practice was aware of their results within regards to patient satisfaction in accessing the practice via telephone and making an appointment. The practice confirmed they had changed their telephone system in June 2018 to include automated directions to different services, such as prescriptions or appointments and call-waiting identification. The practice provided us with evidence of a telephone survey undertaken in September 2018 which demonstrated patients were reporting an improvement in accessing the practice following the installation of the new telephone system.				

Any additional evidence
On the second day of inspection, 15 November 2018, at 10:10am, we reviewed the practice's availability for appointments at all four sites. We found: • At Stakes Lodge, we were informed the next available appointment with a GP was at 2.35pm that day; with a practice nurse at 11.10am that day and a healthcare assistant on 3rd December at 10.20am. • At Forest End, we were informed the next available appointment with a GP was throughout the morning and into the afternoon. Pre-bookable appointments were not available at Forest End, as they were all 'on the day' appointments. The next available appointment with a practice nurse was on 22 November at 11.40am and with a healthcare assistant on 3 December at 7.00pm. • At Westbrook, we were informed the next available with a practice nurse was Tuesday 20th November at 9.00am. No GP appointments were available at Westbrook but patients could access a healthcare assistant appointment, which was next available on Monday 26th November at 9.30am. • At the Health Centre, we were informed the next available appointment with a GP was throughout the morning and into the afternoon. Pre-bookable appointments were not available at the Health Centre, as they were all 'on the day' appointments. The next available appointment with a practice nurse was on 6 December at 2.10pm and with a healthcare assistant was at 11.40am on the day of inspection.

Listening and learning from complaints received

Complaints	Y/N
Number of complaints received in the last year.	119
Number of complaints we examined	12
Number of complaints we examined that were satisfactorily handled in a timely way	12
Number of complaints referred to the Parliamentary and Health Service Ombudsman	0
Additional comments:	
The practice offered information to patients about how to complain about their services via a patient leaflet and via their website. The practice confirmed that both verbal and written complaints were recorded on Quasar which was the	

local Clinical Commissioning Group's incident reporting system. All complaints were recorded by an administrative staff member and monitored until a resolution letter had been issued by the practice. All documents relating to an incident or complaint were scanned and kept on Quasar. The practice confirmed all final letters contained details about referring a complaint to the Parliamentary and Health Service Ombudsman. This information was also provided in the practice leaflet.

The practice confirmed an apology was always offered in line with the Duty of Candour.

We reviewed a selection of minutes from meetings and found that complaints were being discussed in a timely way and learning from complaints were being cascaded to staff via The Tree.

Example of how quality has improved in response to complaints

We were provided with evidence of learning points identified at a complaints meeting held at the practice on 18 July 2018. We were shown that this document had been uploaded to The Tree and staff had been notified. Learning points identified at the meeting included:

- New protocols had been created and uploaded to The Tree regarding 'fit' notes and two-week wait referrals;
- Reminder to reception staff to check waiting areas at shift handover to ensure no patients were still waiting to see a clinician;
- Reminder to clinical staff, when arranging an ultrasound scan or X-ray for a patient, that follow up information on how to confirm an appointment was given to the patient prior to leaving the consultation room.

Any additional evidence

The practice had created their own 'Hub' which was staffed by a team of call handlers and call mentors, supported by a Duty GP. The Hub received all incoming calls to the practice and actioned the calls following protocols accessed from The Tree. The practice provided us with evidence to show that the numbers of calls answered had improved since the Hub was implemented. For example, compared to July-September 2017 when 14,908 incoming calls were recorded, 10,899 of which were answered and 4,009 were abandoned; during June-September 2018, 13,696 incoming calls were recorded, 11,955 were answered and 1,741 were abandoned. The practice reported the drop in overall incoming calls may have been caused by the practice's automated directing service following their telephone system upgrade that directed patients who had a prescription query to a separate line.

The practice had recently upgraded their telephone system in response to the volume of complaints and feedback from patients about its accessibility. The telephone system now included a waiting indicator and an automated direction system so that patients could access the service within the practice that was most suitable to their needs.

The practice had recently devised a link with all the local care homes and were in the process of undertaking visits to each care home. These visits were designed to review patient arrangements to ensure the practice had the correct information recorded for each patient registered at the practice and residing in a care home. During this process, the practice provided evidence to show they had improved the data they stored on patients with regards to do not resuscitate orders, consent to share instructions, medicines reviews, care plans, and treatment escalation plans.

The practice had created a Same Day Care Team which was based at the Health Centre site. The

Same Day Care Team consisted of GPs, nurse practitioners, paramedics and paramedic practitioners. Appointments were not pre-bookable and available as ‘on the day’ appointments.

The practice has developed a close working relationship with MIND over the last 12 months in response to identifying an increase in mental health conditions amongst their patients. The practice confirmed a weekly clinic with a MIND practitioner was facilitated at one of the practice’s sites. The practitioner had access to the practice’s clinical records to ensure patient notes could be updated in a timely manner. The practice had also upskilled their nurse and paramedic practitioners in mental health management techniques so they could support those patients when they contacted the practice for help.

Well-led

Leadership capacity and capability

Examples of how leadership, capacity and capability were demonstrated by the practice
There was a clear management structure in place that was well-established and documented. We were provided with a clear diagram that demonstrated individual roles and line management arrangements. The practice had a registered manager who had been registered with the Care Quality Commission since 2016. The practice confirmed they had successfully undertaken two practice mergers in the previous four years, becoming and continuing to run the four-site practice that they currently were. Three of the sites had its own site or practice manager who monitored the day to day running of each site. These managers then reported to the overall business manager, who reported to the GP partners and Registered Manager.

Vision and strategy

Practice Vision and values
The practice provided evidence of their vision and values via their Statement of Purpose. The practice aimed to deliver high quality care that was closer to home and still met the individual needs of individual patients in the practice's local communities.

Culture

Examples that demonstrate that the practice has a culture of high-quality sustainable care
The practice had access to a wider clinical team through the employment of nurse and paramedic practitioners and pharmacists which created better access to appropriate clinical care for all patients. The practice had created administrative teams that focused on specific areas of non-clinical tasks, such as rota monitoring, and Quality and Outcome Framework monitoring. The practice had devised and created their own Home Visiting Service since 1 September 2018. This was formulated with another local practice but staffed by Vine Medical Group. The practice had created and implemented 'The Tree' as an intranet system to support practice staff in easily accessing appropriate information, protocols and policies at any computer at any site. The practice had created their own 'Hub' which was staffed by a team of call handlers and call mentors, supported by a Duty GP. The Hub received all incoming calls to the practice and actioned the calls following protocols accessed from The Tree. The practice had recently upgraded their telephone system in response to the volume of complaints and feedback from patients about its accessibility. The practice had recently devised a link with all the local care homes and were in the process of undertaking visits to each care home. These visits were designed to review patient arrangements to ensure the practice had the correct information recorded for each patient registered at the practice and residing in a care home. During this process, the practice provided evidence to show they had improved the data they stored on patients with regards to do not resuscitate orders, consent to share instructions,

medicines reviews, care plans, and treatment escalation plans.

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

Source	Feedback
Staff interviews	Staff reported they were supported by managers and colleagues. Non-clinical staff confirmed they could ask for support or advice from the clinical team and they would receive it promptly. Staff stated they enjoyed working at the practice and the clinical staff who worked across several sites confirmed they had appropriate amounts of time to get to each site before starting to see patients.
Staff questionnaires	We received comments from staff that reported Vine Medical Group was a good place to work. Management were supportive and understanding. The practice, although busy and sometimes stressful, was never dull. Staff felt part of a team and supported by colleagues and managers alike. Staff reported the practice was well-organised and provided appropriate supervision. Staff confirmed they enjoyed their work and reported they were happy.

Any additional evidence
The practice provided evidence of a staff wellness survey which ran from June 2017 to July 2018. The practice received 74 responses from a variety of staff. The survey asked if staff would be interested in any well-being activities, either before or after work or during the lunch hour. Of those that responded 82% agreed they would be interested. We did not see any evidence to demonstrate how the practice had responded to this survey.

Governance arrangements

Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.	
Practice specific policies	We reviewed 15 policies and eight protocols used by the practice, such as for repeat prescribing, infection prevention and control, safeguarding, confidentiality, transgender patients, information governance, chaperoning, electronic prescribing, and whistleblowing. All had been reviewed within the previous six months and had a next review date indicated.
Other examples	We saw evidence of other policies which had been created by external parties. For example, the practice used the Duty of Candour policy created by Southern Health NHS Trust. The policy itself had appropriate version control and was due for review in 2019.

	Y/N
Staff were able to describe the governance arrangements	Yes
Staff were clear on their roles and responsibilities	Yes

Any additional evidence
The provider had created their own internal governance system called ‘The Tree’. We were told policies, protocols, clinical guidance and documented minutes from meetings were uploaded and stored on The Tree. When asked, staff confirmed they would routinely access The Tree for information, support and updates. Within the Tree documents were stored under headings of ‘Title’, ‘Category’, ‘Type’, and ‘Review Date’.

The review date section included a countdown timescale which indicated when the document, especially a policy or protocol, was due for review.
The Tree had its own monitoring system for staff training. We were told staff had their own individual profiles and staff would be told when training updates were required. However, on review of the practice's staff training log, we found evidence that showed staff training was not up to date in line with the practice's own policies.
Staff were clear on their own roles and responsibilities but we were told that some staff would prefer to approach a peer colleague rather find out for themselves who was responsible for a specific task. Staff we spoke to confirmed that this was not a regular occurrence but as The Tree contained the information that could support all staff in confirming who was responsible for a specific role, they felt it was inappropriate that this habit was continuing to take place.

The practice had a comprehensive communication schedule that allowed for information to be shared, discussed and reviewed regularly. For example:

- The practice held daily 'huddles' when important information about the upcoming day was shared; the content of the huddle was also loaded on to The Tree for staff to access as 'Huddle News'.
- Every month, the practice held multi-disciplinary critical care meetings, a business meeting with all GPs and lead non-prescriber clinician, and management meetings.
- The practice had also implemented monthly half-day closing sessions for all but skeleton staff which allowed for team meetings, Same Day Care Team meeting with a GP, pharmacy team meeting with a GP, education training and e-learning opportunities.
- On a bi-monthly basis, the practice held partner business meetings.
- Every quarter, the practice held meetings with the patient participation group, a multi-disciplinary team child health hub meeting, as well as a TARGET half-day training that was initiated by the local clinical commissioning group. (TARGET stands for Time for Audit, Research, Governance, Education and Training, and takes place every three months; it is a time for practice staff to learn new skills, hear new research and share best practice).

Managing risks, issues and performance

Major incident planning	Y/N
Major incident plan in place	Yes
Staff trained in preparation for major incident	Yes

Examples of actions taken to address risks identified within the practice

Risk	Example of risk management activities
Lift at Stakes Lodge site	The practice provided evidence of a risk assessment in case the lift at Stakes Lodge should malfunction or breakdown with a patient or employee inside. The risk assessment confirmed the lift had a manual override function and all staff at the site had been shown how to access the manual override. A protocol had been uploaded to The Tree on what to do if the lift malfunctioned. The practice confirmed the lift is serviced annually to maintain its functionality.
Automatic door at Forest End site	The practice provided evidence of a risk assessment for the automatic front doors at the Forest End site. The risk assessment confirmed the doors had been set to operate a slower pace to prevent staff, patients or visitors to the practice getting caught in the doors.

Appropriate and accurate information

Question	Y/N
Staff whose responsibilities include making statutory notifications understood what this entails.	Yes

Engagement with patients, the public, staff and external partners

Feedback from Patient Participation Group;

Feedback
Members from the Patient Participation Group (PPG) confirmed that the practice regularly engaged with them in meetings. The PPG confirmed they held a minimum of four meetings a year and extra meetings were arranged as required. The PPG felt the practice was open and honest with them regarding incidents and complaints as they were discussed during their meetings with the practice. The PPG felt the practice was supportive of the group and took on board the suggestions made by the PPG on how services could be improved by the practice. For example, the PPG had contributed to the planning for the practice to attend the local summer fete, and helped to formulate the guidance that featured in the practice's new telephone system for patients to select an appropriate function.

Continuous improvement and innovation

Examples of improvements demonstrated as a result of clinical audits in past two years

Audit area	Improvement
Leg ulcer audit	The audit demonstrated little improvement to the healing rates for patients. For example, in an audit undertaken between October 2017 and March 2018, a total of 22 patients were seen for an initial assessment. Of those 22, 13 healed within 12 weeks, a further four healed after 12 weeks, and five more were ongoing. A repeat audit undertaken between April and September 2018 reported 22 patients were seen for an initial assessment. Of those 22, 11 healed within 12 weeks, a further one patient healed over 12 weeks, and a further 10 were ongoing at point of data collection. However, the audit demonstrated that systems and processes for leg ulcer treatment had improved. For example, the creation of a specific leg ulcer clinic for continuity of care, and the introduced of tissue viability meetings between the nursing staff had been helpful in communicating and resolving any issues encountered during the ulcer clinics.
Methotrexate audit	The practice became aware that the practice was not following or recording shared care protocols, nor monitoring blood tests for patients who were receiving Methotrexate. The practice performed an initial audit to identify the severity of the problem. In November 2017, 138 patients were identified as taking Methotrexate, of those 138, only 76 had shared care instructions. The audit did not record the number of patients overdue a blood test. Actions from this audit included: • The recording of shared care instructions in the same place for all patients;

	• Creating a medicines management pathway once the patient is started on Methotrexate; • The provision of information and education to all patients receiving Methotrexate. • The provision of education regarding Methotrexate to all clinicians at the practice. A repeat audit undertaken in August 2018 showed that 123 patients receiving Methotrexate. Of those 123, 119 now had shared care instructions, and 21 were overdue a blood test.

Any additional evidence

The practice provided evidence of an audit that recorded the 'patient footfall' at one site on 21 May 2018 between the hours of 8am and 9am. The practice recorded 95 individual occurrences during that time period. Of those 95, 29 were recorded to be patients attending for a booked appointment. A further 16 occurrences were to either book or cancel an appointment. Another four occurrences were identified as patients attending the wrong site for an appointment. We were not informed what the practice planned to do with this information.

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 comparable, 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 comparable to other practices.

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

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	Z ≤-3
2	Variation (positive)	-3 < Z ≤ -2
3	Comparable to other practices	-2 < Z < 2
4	Variation (negative)	2 ≤ Z < 3
5	Significant variation (negative)	Z ≥3
6	No data	Null

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.

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:

http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease
- **PHE**: Public Health England

- **QOF**: Quality and Outcomes Framework (see https://qof.digital.nhs.uk/).
- **RCP**: Royal College of Physicians.
- **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.(See NHS Choices for more details).