

Care Quality Commission

Inspection Evidence Table

Fiveways Health Centre (1-3833238553)

Inspection date: 9 May 2019

Date of data download: 07 May 2019

Overall rating: Requires Improvement

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

Safe

Rating: Inadequate

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	N
There was active and appropriate engagement in local safeguarding processes.	N
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
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.	N
Explanation of any answers and additional evidence:	

Safeguarding	Y/N/Partial
<p>Following the November 2018 inspection CQC made a decision to impose conditions on the provider's registration. On 12 November 2018 we wrote to the provider stating:</p> <p>By 8am on 19 November 2018, the registered persons must have an effective process in place to ensure that an accurate record is held for all patients identified who are at risk from abuse or improper treatment, including patients on a child protection or a vulnerable adult plan.</p> <p>The conditions also stated:</p> <p>By 8am on 19 November 2018, the registered persons must have an effective process in place to assess and monitor the systems used at Fiveways Health Centre to identify, manage and share information with partners and stakeholders about children and vulnerable adults who are at risk from abuse or improper treatment.</p> <ul style="list-style-type: none"> • Since the inspection in November 2018 the practice had reviewed their safeguarding systems to ensure they were up to date and had a system for monitoring, in order to protect patients at risk of harm. We found that the safeguard lead had reviewed some of the safeguarding registers, However, they told us that they had not reviewed the records of patients on the children's cause for concern register, on which there were five patients. • The practice did not demonstrate a proactive approach to developing joint working arrangements with health and social care professionals involved in safeguarding, to ensure a formal approach was in place. They had not met with any partners or stakeholders, such as health visitors, to plan the implementation of safe systems. • The practice had set up a Female Genital Mutilation (FGM) register and carried out relevant searches to identify patients who had suffered FGM. The register showed patients who had undergone FGM, and alerts were added to patients records. A second register identified which patients were at risk. • Most staff had completed safeguarding training appropriate for their role, however the partners had only completed 'Safeguarding Adults' at level one. Following the inspection, the registered manager completed level two safeguarding adults. • The registered manager was not aware of the competency framework set out in the intercollegiate guidance for all clinical staff working with children, young people and/or their parents/carers required level three training, this included practice nurses. 	

Recruitment systems	Y/N/Partial
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.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff had any necessary medical indemnity insurance.	Partial
Explanation of any answers and additional evidence:	

- During the most recent inspection we found inconsistencies in the information that was provided to the inspection team. Recent recruitment had taken place, but we were unable to establish that the recruitment policy had been followed and an appropriate interview process had been undertaken. During the inspection the leadership team were unable to articulate when the interview had taken place or who had undertaken the interview. Following the inspection, the practice provided a statement stating interviews had taken place, however they provided no evidence to support this.
- At the time of the inspection the lead GP had indemnity insurance to cover two clinical sessions, however the plan was for the GP to do increased clinical and administration sessions to ten per week as well as management and supervision sessions. We found no evidence to confirm that the clinical lead had considered or reviewed his insurance to ensure it was adequate to cover his responsibilities.

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: October 2018	Y
There was a record of equipment calibration. Date of last calibration: October 2018	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: June 2018	Y
There was a log of fire drills. Date of last drill: November 2018	Y
There was a record of fire alarm checks. Date of last check: March 2019	Y
There was a record of fire training for staff. Date of last training: Various	Partial
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: September 2018	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had implemented a range of risk assessments to ensure the premises were monitored on a regular basis. This included regular training for staff, however, the registered manager had not completed this training. There were six monthly reviews of the fire alarm systems and regular maintenance of the fire extinguishers. • The fire alarms were tested weekly and the emergency lighting on a monthly basis. 	

- Fire drills were carried out every six months.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: February 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: February 2019	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Since the previous inspection the practice had reviewed their processes for the management of environmental risk and had implemented a wide range of checks to ensure risks were mitigated and regular monitoring was built in to the regular duties of the staff. For example: • Monthly legionella checks were completed with weekly flushing of the water systems. • Vaccine storage audits were completed on a monthly basis. Evidence provided by the practice showed the latest one had been completed in April 2019. • The registered manager told us that their role would be the monitoring of systems and processes, including risk management processes performed by the acting practice manager. They told us that the governance arrangements for this role had not been established and there was no clear plan for the development and implementation of the checks. The competencies for this role had not been considered and we found that they had not completed some of the required training that the practice considered to be mandatory. Following the inspection, the registered manager completed online training to support his role. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Partial
Date of last infection prevention and control audit: October 2018 Practice achievement: 98%	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had a comprehensive system in place to monitor infection prevention. We found that most staff had completed the relevant training specific to their role, there was training that the practice considered mandatory which had not been completed by the registered manager, the monitoring system in place had not addressed this. Following the inspection, the registered manager completed a selection of online training. • The audit had identified that the sinks had overflows. The practice planned to have these changed when the next refurbishment of the premises was organised. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	N
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Partial
Risk management plans for patients were developed in line with national guidance.	Partial
Panic alarms were fitted, and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Partial
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> There was no clear plan or schedule for commencing patient consultations. The leadership team gave different versions of what the schedule may be. They told us that there would be 15 clinical sessions per week and that the GP clinical lead would cover eight of these, plus two administration sessions. They told us that locums would be used to cover the remaining sessions, however we found that clinical cover arrangements had not been formally considered, the leadership team articulated an ad hoc approach to ensuring appropriate and sustained clinical cover. The acting practice manager was unaware of the plans to arrange appropriate clinical cover by the registered manager. Following the inspection, the registered manager sent a schedule for clinical consultations, however they were unable to demonstrate that these had been considered prior to the inspection. The clinical lead demonstrated the knowledge to manage patient care, however as the practice was not delivering care and treatment at the time of the inspection they were unable to demonstrate the effectiveness of their processes. The lead GP was aware of NICE guidance; however, when asked he was unable to demonstrate knowledge of any recent guidance issued. The practice had developed processes to monitor patients' care and treatment, as there were no patients currently being seen at the practice these were not yet in use. Most staff had completed sepsis training relevant to their role. The registered manager, who covered reception had not completed this training, they told us they had received guidance during a meeting with the Local Medical Council (LMC), however were unable to evidence this. The 	

registered manager sent evidence to show that this training had been completed online following the inspection.

Information to deliver safe care and treatment

Staff did not have 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.	N/A
There was a system for processing information relating to new patients including the summarising of new patient notes.	N/A
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	N/A
Referral letters contained specific information to allow appropriate and timely referrals.	N/A
Referrals to specialist services were documented.	N/A
There was a system to monitor delays in referrals.	N/A
There was a documented approach to the management of test results and this was managed in a timely manner.	N/A
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	N/A
Explanation of any answers and additional evidence: The practice were not currently providing regulated activities to patients, therefore we did not review all of the areas listed above. <ul style="list-style-type: none"> At a previous inspection we identified a delay in sending clinical correspondence to the caretaking practice. We found at this inspection that a system had been implemented to ensure post was sent in a timely manner. All post received was date stamped and logged in a record book and a member of the practice team delivered the correspondence to the caretaking team. We saw evidence to confirm that all post was managed effectively. 	

Appropriate and safe use of medicines

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	N/A

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.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	N/A
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.	N/A
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.	N/A
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N/A
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	N/A
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.	N/A
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice were not currently providing regulated activities to patients, therefore we did not review all of the areas listed above.</p> <ul style="list-style-type: none"> The practice had a range of processes in place to monitor stock levels and expiry dates and to ensure medical equipment and vaccines were stored appropriately. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial

There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded since the last inspection in November 2018:	2
Number of events that required action:	2
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Since the previous inspection the practice had reviewed and improved their processes for the recording and actioning of incidents to mitigate future risk. They had done this with the support of an external mentor who had supported the practice manager to develop systems and processes. • We found that not all members of the leadership team were clear as to the process for recording significant events. • We found systems had been implemented to ensure learning was shared with staff and with external organisations through online incident reporting database. 	

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

Event	Specific action taken
Incomplete registrations	A patient attended the caretaking practice for some paperwork but found that they were not registered. Fiveways Health Centre completed an audit and found three further registrations had not been completed. The revised list of patients was sent to the caretaking practice for actioning.
Incorrect prescribing	<p>On reviewing a patient's record, a patient had been prescribed a medicine that was not prescribed for them. The mistake had occurred as the medicine had been added to the wrong patient record. Fiveways Health Centre completed a search to identify which patient should have been prescribed the medicine. Information was sent to the caretaking practice for actioning.</p> <p>There had been no system put in place to minimise the risk of further occurrence.</p>

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had reviewed their systems since the last inspection to implement an effective process for the management and actioning of safety alerts. We found that alerts were received through a web-based sharing and compliance system the practice had inhouse and disseminated to the clinical lead for action. We were told by the acting practice manager that as a safety net, the management team also reviewed alert safety websites where alerts were issued to ensure all had been received by the practice. This ensured that no alerts were missed and risks to patients were mitigated. During the inspection we found that the lead for patient safety 	

alerts was not proficient in accessing alerts.

Well-led

Rating: Inadequate

Leadership capacity and capability

Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Following the November 2018 inspection CQC made a decision to impose conditions on the provider's registration. On 12 November we wrote to the provider stating:</p> <p>By 16 November 2018, the registered persons must send written documentation to the Care Quality Commission setting out what steps have been taken to ensure the practice is managed by a named person or persons who have the necessary qualifications, competence, skills and experience to manage the carrying on of the regulated activities.</p> <ul style="list-style-type: none">• The practice had commissioned the services of a consultancy group to support them in the implementation of effective governance processes. This included training and support for the acting practice manager to develop their role. Whilst the arrangements and support had since concluded the provider informed us they would engage further if required.• The provider had organised for a mentor to be available on a weekly basis to offer guidance and support to the practice manager. The provider told us that this was an ongoing arrangement which would continue.• We were told that the clinical partner, who had previously retired, would be undertaking clinical sessions full time for a period of approximately 12 months. The provider did not demonstrate that any succession planning had taken place.• There had been four CQC inspections prior to this inspection, the first being January 2018. In June 2018 due to significant concerns CQC had suspended the provider's registration, the suspension ended in November 2018, however patients remained at the caretaking practice, this was being managed by the CCG. During this time the provider had taken some action to understand and address the concerns and challenges, however they did not demonstrate they had developed effective plans to ensure continued improvements were made and sustained. Nor had they actively engaged with the care taking practice or the CCG to facilitate the transfer back of patients.• The leadership team were inconsistent in how they articulated what clinical sessions were required to meet patients' needs and how clinics would be covered. There was no evidence that patient demand had been considered or a structure of clinical support and capacity developed. Whilst all reported fifteen clinical sessions per week were required, each member of the leadership team gave a different schedule of clinics. The provider was unable to demonstrate that the clinical sessions to be undertaken by the practice nurse had been considered and agreed prior to employment being offered, there was also some confusion between the leadership team as to the remit of the nurse's role. The practice was therefore unable to demonstrate they had	

plans in place to ensure the practice had the appropriate levels of staffing to ensure patients' needs would be met and no plans to monitor how to ensure resources were managed appropriately in the future. Following the inspection, the provider sent us a schedule of clinical sessions, however it was evident that this had not been considered a priority prior to the inspection.

- We were told that a female GP was willing to work three sessions per week at the practice, however there was no formal agreement or plan in place to confirm this would go ahead. The registered manager was unable to provide the name of this GP.
- The leadership team did not demonstrate a shared vision, there were occasions when they gave contradicting responses to our questions. This did not demonstrate an effective approach to leadership had been developed and embedded.

Vision and strategy

The practice had a clear vision, but it was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial
There was a realistic strategy to achieve their priorities.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Since the previous inspection the practice had sought support from external agencies to support the development of safe systems and processes. We found that the practice had a set of values that had been shared with the practice team. The values were: Quality Care, Patient Safety and Patient Satisfaction. These were communicated with staff. • There was no evidence of collaborative working with stakeholders. There had been no consideration, engagement or development in how the practice would work within a Primary Care Network (PCN) to deliver sustainable care. Following the inspection, the provider informed us that contact had been made with a PCN and discussions on the practice's involvement were due to commence. • The provider had not considered how to involve patients in the development of the strategy • The strategy was for the clinical lead to work full time at the practice, delivering eight clinical sessions and oversee all the clinical areas, including the clinical management of the practice and supervision of the clinical team. We were told this was the short-term plan until the practice was able to move forward, however the practice was unable to demonstrate they had considered any actions after this. 	

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.	Y
There was a strong emphasis on the safety and well-being of staff.	Partial
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We were told that a nurse was 'recruitment ready' for when the practice re opened. One staff member was training as a health care assistant (HCA), supported by the practice. The practice was unable to demonstrate the nursing hours and clinics required to meet the needs of patients had been discussed and agreed with staff to ensure appropriate capacity to meet patients' needs. The registered manager told us that the nurse would be working late evening and weekend if required, but there was no record that the nurse was aware of this. The existing practice staff demonstrated a team approach and were committed to moving the practice forward. 	

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

Source	Feedback
Staff	<ul style="list-style-type: none"> Staff told us that during the time they not been providing a service, training and updates have taken place to ensure all staff are aware of the procedures and policies they had to follow. However, we also found the clinical lead was unable to locate a specific policy, for which they were the lead. Staff said they were all a team at the practice and supported each other.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had brought in an external company to support them with developing their governance processes. A 13-week programme had been completed by the practice team. The programme assisted staff in their role including practice management, clinical coding and the 	

implementation of assessments to monitor risk.

- Policies and processes had been introduced, these were being managed by the acting practice manager. The clinical lead demonstrated a general lack of awareness of how to access policies, for example when asked for the DMARD policy (Disease-modifying antirheumatic drugs) he was unsure if there was one, or where it would be located. As the clinical lead in the practice, it would have been appropriate for him to have developed this policy. The acting practice manager was able to locate this for him.
- The responsibilities of the management team were not always clear. For example: we found that the acting practice manager was the lead for risk management. They told us they would have a monitoring role in this area. The role and supporting governance had not yet been established.
- There was no formal structure in place to ensure appropriate clinical cover was in place to meet patients' needs. We found that there was no agreed schedule of clinics and there was an ad hoc approach to ensuring clinical capacity would be available.
- There were no business continuity plans in place to ensure services were maintained whilst waiting for the nurse and the HCA to take up their roles.
- The acting practice manager had a system for engaging with locum agencies and a list of checks that would be required prior to commencing clinical duties. The registered manager discussed the use of a 'WhatsApp' group to cover clinical sessions, they were unable to articulate the governance arrangements in place, they did however provide a list of checks that would be made. The acting practice manager was not aware of the 'WhatsApp' group for locum use.
- We found that the practice had not followed a recruitment process when interviewing the practice nurse, conversations with the leadership and documentation viewed suggested a formal interview had not taken place. Following the inspection, the provider wrote to us stating there had been confusion regarding the interview, but they provided no additional evidence to support this.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had completed some audits, however as they were not providing any services at the time of the inspection, they were not in a position to demonstrate if the audits would have demonstrated quality improvements. • The practice had considered the changes it wanted to implement. However, they did not demonstrate that business needs and clinical capacity had been considered. There was no 	

formal plan available to show how sustainability would be maintained.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	N/A
Our inspection indicated that information was accurate, valid, reliable and timely.	N/A
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
<p>The practice were not currently providing regulated activities to patients, therefore we did not review all of the areas listed above.</p> <ul style="list-style-type: none"> At the time of inspection, the practice was not providing services. The practice had implemented a range of risk assessments to manage the practice premises and facilities and to mitigate risk. The practice monitored information relevant to the practice to assess what improvements were required and to implement a strategy to improve performance. 	

Engagement with patients, the public, staff and external partners

The practice did not involve the public and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	N/A
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice staff had worked together, with the support of an external agency to ensure systems and processes for the management of the practice were developed. We found there was a lack of communication between stakeholders and the practice. Patients registered at Fiveways Health Centre were receiving care and treatment from a caretaking practice. We found that the provider had not proactively engaged with the clinical commissioning group to provide the required assurance that contractual breaches had been addressed, which would enable the return of patients to the practice. The CCG ran 'Protected Learning Time' events for all member practices. We found that no 	

members of the practice team had attended the most recent event, despite the CCG funding clinical cover so that all practices could attend.

- A primary care network (PCN) consists of groups of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, co-ordinated health and social care to their local populations. Practices with West Birmingham and Sandwell CCG are required to formally sign up to the PCN by 15 May 2019. We found, at the time of the inspection, the practice was not engaging with the local primary care network nor had they attended any of the events organised by the CCG.

Continuous improvement and innovation

There was some evidence of systems and processes for learning and improvement.

	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:	
<ul style="list-style-type: none"> • The practice had invested in their team and the acting practice manager was being supported by a mentor on a weekly basis to support their training and development within the role. • We found examples of systems which had been developed but that were not functioning as intended, for example the oversight of training and the process for recruitment. • Further training had been provided for one of the reception staff who was currently training to be a healthcare assistant. • The practice shared their ideas to make improvements to the practice and had a range of procedures in place for implementation. • The practice had not considered the importance of engagement with the primary care network (PCN). There had been no engagement with the PCN in readiness for signing the required formal agreement on 15 May 2019. Practices with West Birmingham and Sandwell CCG are required to formally sign up to the PCN by 15 May 2019. We found, at the time of the inspection, the practice was not engaging with the local primary care network nor had they attended any of the events organised by the CCG. 	

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.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

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

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

Glossary of terms used in the data.

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