Care Quality Commission

Inspection Evidence Table

The Acocks Green Medical Centre (1-584619226)

Inspection date: 26 June 2019

Date of data download: 10 June 2019

Overall rating: Inadequate

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

Safe Rating: Inadequate

Safety systems and processes

We identified areas where the practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	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).	Y
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Partial
There was a risk register of specific patients.	N
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.	Y
Explanation of any answers and additional evidence: • Although there were some systems to identify vulnerable patients and evidence of safeguarding	

Safeguarding	Y/N/Partial
meetings with other health and social care professionals, we found that there was no clear register in place for children at risk and the practice was unable to effectively demonstrate regular review of their registers for vulnerable children including those at risk and on child protection registers. • In addition, the service did not provide evidence to support or assure us that where relevant, family members were linked to child safeguarding cases such as those at risk and on child protection registers.	

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.	Y
Explanation of any answers and additional evidence: • The practice had strengthened their systems for the management of staff immunisations and ensured this was maintained in line with current Public Health England (PHE) guidance where relevant to role. • There were gaps in the evidence provided during our inspection to demonstrate that recruitment checks were carried out in accordance with regulations. For example, there was no evidence of references obtained to satisfy evidence of conduct in previous employment or education for one of the GPs, the practice employed pharmacist and a member of the nursing team. Although we also saw contracts in place for these staff members, we noted that they had not been signed.	

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: 22/11/2019	Y
There was a record of equipment calibration. Date of last calibration: 22/11/2019	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: 21/6/2019	Y
There was a log of fire drills. Date of last drill: 4/2/2019	Y
There was a record of fire alarm checks. Date of last check: 10/6/2019	Y
There was a record of fire training for staff. Date of last training: 22/6/2019	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 22/11/2018	Y
Actions from fire risk assessment were identified and completed.	Y

Explanation of any answers and additional evidence: • We saw that actions from the fire risk assessment were completed in areas including the implementation of clearer signage on the exterior fire exit doors to prevent obstruction in the event of a fire drill or an evacuation.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 22/11/2018	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 22/11/2018	Y
Explanation of any answers and additional evidence: • There was evidence in place to support that the practice revisited and reviewed risk assessments pertaining to the health, safety, fire and security of the premises.	

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.	Y
Date of last infection prevention and control audit:	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: • The practice revisited and reviewed risk assessments with regards to infection prevent and control, this included risk assessments for the Control of Substances Hazardous (COSHH) and risk of legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings. • There were safe arrangements for managing clinical waste and there was evidence of cleaning schedules and completed records in place to reflect the cleaning of the premises and medical equipment.	

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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y

Risk management plans for patients were developed in line with national guidance.	Y
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.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence: N/A	

Information to deliver safe care and treatment

There was evidence to support that in some areas, staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
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.	Y
Explanation of any answers and additional evidence: • Our review of the practices pathology results system during our inspection highlighted 12 results which had not yet been opened and viewed by a GP, although these results were not significantly overdue and were recently dated (as 24 June and 25 June 2019), however, we noted that several of them were marked as urgent.	

Appropriate and safe use of medicines

There were gaps in the practices systems for the appropriate and safe use of medicines, including medicines optimisation.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA)	0.68	0.84	0.88	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2018 to 31/03/2019) (NHSBSA)	6.1%	7.7%	8.7%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2018 to 31/03/2019) (NHSBSA)	6.11	5.13	5.61	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA)	1.81	1.78	2.07	No statistical variation

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).	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	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
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.	Y
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	Y

Medicines management	Y/N/Partial
appropriate monitoring and clinical review prior to prescribing.	
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
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

Explanation of any answers and additional evidence:

- The practice had formally assessed risk in the absence of emergency medicines used for suspected meningitis and croup in children, the assessment demonstrated that risk was managed by accessing these medicines if needed through the pharmacy which was based on the premises.
- Although we found no concerns specific to the prescribing competence of the nurse prescriber, there was no formal evidence provided by the practice to demonstrate a regular review of their nurses prescribing practice was in place, supported by clinical supervision or peer review. Our discussions with members of the clinical team confirmed that formal auditing was not currently taking place and that informal support and supervision was available when needed.

During our inspection we noted that although there was evidence of structured and regular medicines reviews for patients on some medicines, in other areas reviews were significantly overdue. For example:

- Our review of the patient record system highlighted 36 patients with hypertension who were prescribed a specific medicine and were overdue reviews in line with guidance from the Medicines and Healthcare products Regulatory Agency (MHRA).
- We also identified 150 patients on ACE inhibitors (medicines commonly used to treat heart failure and high blood pressure) that were overdue reviews.
- In response to our request for assurance the practice provided evidence of an audit completed following the inspection to confirm that patients taking a specific medicine for hypertension, for patients taking ACE inhibitors and for those taking these medicines on a long-term basis due to risk of certain cancers had since been reviewed.

Track record on safety and lessons learned and improvements made

Evidence highlighted that the practice had not always 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.	Y
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 in last 12 months:	8
Number of events that required action:	8

Explanation of any answers and additional evidence:

- There was evidence demonstrating an active approach to recording incidents and significant events, this also included positive events.
- Records demonstrated that these were discussed when identified and during formal practice meetings. Trends, themes and training needs from significant events were further discussed during annual reviews.
- However, our review of significant events highlighted that embedding changes to prevent recurrence and to improve was not fully effective in certain areas.

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Guidelines not followed with regards to prescribing specific antibiotics in pregnancy.	• Incident formally recorded. Pregnant patient showing resistance to specific antibiotics and therefore an alternative antibiotic was prescribed when presenting with a urinary tract infection (UTI). Records noted that the pharmacist refused to dispense the alternative antibiotic medicines due to current guidelines which advised not to prescribe the specific medicine in pregnancy. • Records highlighted that the current guidelines were not widely known by practice staff, actions applied to the incident reporting record included making guidelines available for staff to reference to and to liaise with the medicines team to locate current guidelines. The date to complete this action was 30 June 2019 and we found no further occurrence of this particular matter. Following our inspection the practice provided evidence to demonstrate that local guidelines were adhered to in this particular case. However, during our inspection we noted a theme highlighting that in some areas, staff were not up to date with current guidelines and safety alerts.
Baby immunisations given earlier than required.	• Incident formally recorded. Records highlighted that the incident occurred due to an admin error and failure by clinicians in checking the child's age. Records noted that an open discussion took place with the child's mother and care advice given, further advice was also sought from the West Midlands Immunisation and Screening

	Support team at NHS England. The practice made further contact with the child's mother following the incident to provide further reassurance and to confirm the child's ongoing immunisation schedule. • To prevent recurrence, the incident was shared and reflected on in the practice. In addition, clinicians were reminded to check patients age before each vaccination. We saw that the incident was discussed during a practice meeting and as part of the annual significant event review, staff were reminded to be more vigilant, records confirmed that there had been no further incidents of this nature. Training updates for immunisations were also organised.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial

Explanation of any answers and additional evidence:

- During our inspection we identified gaps in the practices system for the receipt of safety alerts, therefore the practice was unable to demonstrate or provide assurance that they had received and acted on all relevant alerts. For instance the practice was unable to evidence receipt of a November 2018 drug safety alert from the Medicines and Healthcare products Regulatory Agency (MHRA). This alert contained guidance for reviews of patients taking a specific medicine for hypertension and for those taking these medicines on a long-term basis due to risk of certain cancers.
- Following our inspection the practice provided evidence to demonstrate that they had conducted a review of historical MHRA alerts to ensure action was taken where needed, this was in response to our request for assurance. The practice also completed a significant event where they highlighted gaps in the alerts system with their system provider to help mitigate the risk of future alerts being missed.
- In addition, in response to our request for assurance the practice provided evidence of an audit following the inspection to confirm that patients taking a specific medicine for hypertension and for those taking these medicines on a long-term basis due to risk of certain cancers had since been reviewed.

Effective Rating: Inadequate

Effective needs assessment, care and treatment

Patients' needs were not always effectively assessed, and therefore care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial

The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways were in place to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y

Explanation of any answers and additional evidence:

- Whilst we observed some evidence to support that clinicians followed evidence-based practices and guidelines which were also shared in practice meetings through case reviews, in some areas we found gaps in the practices systems and processes to keep clinicians up to date with current guidelines. This was evident through our findings of patients that were overdue medicines reviews in specific areas.
- In addition, we identified a cohort of patients that had been prescribed a contraceptive medicine; this cohort consisted of several patients over the age of 35, all of which were identified as smokers. The practice was unable to demonstrate that these patients had been reviewed and that considerations to altering their medicines had been applied in line with guidance from the National Institute for Health and Care Excellence (NICE). This therefore highlighted that the practices systems and processes to keep clinicians up to date with current evidence-based practice was not effective.
- In response to our request for assurance the practice provided evidence of an audit completed since the inspection to confirm that within this cohort who were prescribed a contraceptive medicine had been reviewed.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) (NHSBSA)	1.17	0.75	0.77	No statistical variation

Older people — Population group rating: Inadequate

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- However, the overarching inspection findings highlighted that patients' needs were not always effectively assessed, and therefore care and treatment was not always delivered in line with current

legislation, standards and evidence-based guidance supported by clear pathways and tools.

People with long-term conditions Population group rating: Inadequate

Findings

- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- However, our review of the patient record system highlighted a number of patients that were prescribed medicines for hypertension which were overdue reviews.
- Furthermore, the practices patient record system highlighted that 505 patients were on ACE inhibitors (medicines commonly used to treat heart failure and high blood pressure), 150 (30%) of these were overdue reviews, specifically 34 cases hadn't had a review in more than two years and 116 cases hadn't had a review in more than one year.
- In in response to our request for assurance the practice provided evidence of an audit following the inspection to confirm that patients taking a specific medicine for hypertension, for patients taking ACE inhibitors and for those taking these medicines on a long-term basis due to risk of certain cancers had since been reviewed.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins. Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	79.6%	79.9%	78.8%	No statistical variation
Exception rate (number of exceptions).	11.0% (35)	12.4%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	72.3%	77.2%	77.7%	No statistical variation
Exception rate (number of exceptions).	3.8% (12)	10.4%	9.8%	N/A

	Practice	CCG	England	England

		average	average	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)	72.8%	81.0%	80.1%	No statistical variation
Exception rate (number of exceptions).	5.6% (18)	11.6%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	79.3%	76.6%	76.0%	No statistical variation
Exception rate (number of exceptions).	4.3% (14)	6.2%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	92.0%	91.3%	89.7%	No statistical variation
Exception rate (number of exceptions).	4.8% (5)	11.2%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	82.5%	83.1%	82.6%	No statistical variation
Exception rate (number of exceptions).	3.0% (18)	4.5%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	82.4%	88.6%	90.0%	No statistical variation
Exception rate (number of exceptions).	0 (0)	8.1%	6.7%	N/A

Any additional evidence or comments
Results 2017/18 Quality and Outcomes Framework (QOF) highlighted no statistical variation across care for patients with long term conditions.

Families, children and young people Population group rating: Inadequate

Findings

- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets in certain areas.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Although the practice described the arrangements in place for following up failed attendance of children's appointments in secondary care, we found that the practice was not effectively capturing these instances on the patient record system; as they were coded as a general missed appointment and did not clearly differentiate between a missed appointment in primary or secondary care.
- We were assured that the practice followed up on missed appointments for childhood immunisations and would liaise with health visitors when necessary.
- Young people were could access services for sexual health and were signposted to Umbrella contraception services if and when appropriate; these services offer a range of free contraception.

Child Immunisation	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) (01/04/2017 to 31/03/2018) (NHS England)	69	73	94.5%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	72	80	90.0%	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) (01/04/2017 to 31/03/2018) (NHS England)	71	80	88.8%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles,	70	80	87.5%	Below 90% minimum (variation

mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)				negative)

Any additional evidence or comments

- During our inspection members of the management team explained that the practice had In engaged with the Public Health England (PHE) Quality Immunisation Improvement scheme in 2017/18 to increase uptake. We noted that performance had improved for primary vaccinations and Pneumococcal boosters when comparing 2016/17 World Health Organisation (WHO) target data with 2017/18 WHO targets. However uptake was consistently below the WHO targets for Haemophilus influenza type b (Hib), Meningitis C and MMR immunisations.
- Conversations with staff during our inspection indicated that the practice were continuing to call, recall and encourage attendance for childhood immunisations and that they were focusing on education to enhance vaccination awareness and improve uptake of these in children.
- Data for the last financial quarter of 2018 demonstrated that the practice was meeting targets across all childhood immunisations, although this was based on one quarter worth of data which was also unverified and unpublished.

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

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- However, during our inspection we found that the practice was unable to demonstrate that clinicians were kept up to date with current evidence-based practice. We found specific evidence pertaining to patients that had been prescribed a contraceptive medicine over the age of 35, all of which were identified as smokers. The practice was unable to demonstrate that these patients had been reviewed and that considerations to altering their medicines had been applied in line with guidance from the National Institute for Health and Care Excellence (NICE).
- In response to our request for assurance the practice provided evidence of an audit completed since the inspection to confirm that within this cohort who were prescribed a contraceptive medicine had been reviewed. In specific areas, cancer screening uptake was consistently below local and national averages when comparing 2016/17 Public Health England (PHE) data with 2017/18 PHE data.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to	53.0%	68.1%	71.7%	Significant Variation (negative)

49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) **(PHE)**	59.8%	63.7%	70.0%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) **(PHE)**	32.8%	43.9%	54.5%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) **(PHE)**	80.0%	74.1%	70.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	37.5%	52.0%	51.9%	No statistical variation

Any additional evidence or comments

- Although the practice provided a report at the time of our inspection to demonstrate that the cervical screening uptake had increased to 72%, this was based on unpublished, unverified data. In addition, We noted that cervical and breast screening uptake was consistently below local and national averages when comparing 2016/17 Public Health England (PHE) data with 2017/18 PHE data.
- PHE data highlighted that bowel cancer screening was consistently below local and national averages for 2016/17 and 2017/18, during our inspection the practice provided data from a member of the cancer research team at the Heart of England Trust, this was unverified and unpublished data however the data noted an improved uptake in bowel cancer screening from 30.85% in 2017 to 46.66% in 2018.
- During our inspection members of the management team explained that they were currently in discussion with local places of worship to educate patients with various cultural and religious needs to encourage screening uptake. As they were in the early stages of this approach no formal evidence was available to support this at the time of our inspection however we noted that this was factored in to the practices formal business plan for achievement over one, three and five years.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- Patients with a learning disability had a structured annual review to check their health and medicines needs were being met. Data provided by the practice demonstrated that out of 51 patients on the register, 18 had received a health check for the current financial year so far; this was unverified and unpublished data.

- The practice demonstrated that they had a system to identify people who misused substances. The practice reviewed patients at local residential homes.
- However, the overarching inspection findings highlighted that patients' needs were not always effectively assessed, and therefore care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- However, the overarching inspection findings highlighted that patients' needs were not always effectively assessed, and therefore care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	92.1%	93.2%	89.5%	No statistical variation
Exception rate (number of exceptions).	5.0% (4)	9.5%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	90.8%	93.3%	90.0%	No statistical variation
Exception rate (number of exceptions).	5.0% (4)	7.8%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	92.3%	86.2%	83.0%	No statistical variation

Exception rate (number of exceptions).	3.7% (1)	6.0%	6.6%	N/A

Any additional evidence or comments
Results 2017/18 Quality and Outcomes Framework (QOF) highlighted no statistical variation across care for patients experiencing poor mental health.

Monitoring care and treatment

The practice had a programme of quality improvement activity however this was not always effective.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	548.3	545.3	537.5
Overall QOF exception reporting (all domains)	5.8%	6.1%	5.8%

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

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

The practice conducted regular searches and audits to identify and embed improvements within the practice. For example, we saw records of a completed audit on antibiotic prescribing, this had been repeated in November 2018. The audit demonstrated improvements in documentation and adherence to formulary. Although we saw that as part of the audit, action plans were implemented to drive improvements in specific areas such as for the prescribing of antibiotics for urinary tract infections (UTIs), our review of the practices significant events highlighted a case logged in May 2019 whereby a specific antibiotic was prescribed to a pregnant patient with a UTI and the prescribing of this medicine did not reflect current guidelines. This indicated that the action from the audit had not been fully effective.

Effective staffing

The practice was unable to demonstrate how they ensured that staff had the skills, knowledge and experience to carry out their roles and all areas.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y

There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

- As part of our inspection we observed the practices appointment system and noted occasions when the lead GP was not in clinic and some days where there were only nurses in clinic. On discussing this with members of the management team, we were informed that on some days when the lead GP was not in clinic they were on the premises undertaking other duties such as managing correspondence, attending meetings and completing administrative tasks.
- The lead GP assured us that the nurses had direct access to them for advice and guidance if needed in the event that there were any occasions where no GPs were on the premises, furthermore they confirmed that the Health Care Assistant only worked in clinics when a GP was on the premises. Our discussions with members of the clinical team confirmed that informal support and supervision was available when needed. However, there was no formal evidence provided by the practice to demonstrate a regular review of their nurses such as formal clinical supervision or peer review. Following the inspection, the practice provided evidence to support that skill mix and competency checks for Human Resources were continually monitored. In addition we saw minutes of a meeting highlighting that a nurse audit was to be completed on medication however evidence of this was not provided during the inspection.
- Furthermore, during our inspection we identified instances where a member of the nursing team had acted out of scope by signing and issuing Statement of Fitness for Work notes (also known as fit notes), these notes can only legally be issued by a GP. Following our inspection the practice provided assurance to confirm that patients who had been issued with a fit note by any persons other than a GP had been notified and were called to the practice to collect their re-issued fit notes; this was in response to our request for assurance.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y

Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
Explanation of any answers and additional evidence: • We saw evidence to support that patients receiving palliative care had information shared in a timely and effective way and received joined up care as required.	

Helping patients to live healthier lives

There was evidence to demonstrate that staff were consistent and proactive in helping patients to live healthier lives.

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

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	95.8%	96.1%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.2% (2)	0.6%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering	Y

consent and decision making. We saw that consent was documented.	
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Explanation of any answers and additional evidence: • Discussions with clinical staff demonstrated that they understood best practice guidance for obtaining consent.	

Caring Rating: Good

Kindness, respect and compassion

Feedback from patients was mostly positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

CQC comments cards	
Total comments cards received.	16
Number of CQC comments received which were positive about the service.	15
Number of comments cards received which were mixed about the service.	1
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC Comment Cards	Comment cards described a caring service overall and staff were described as friendly and helpful. We received one comment which contained mixed feedback, highlighting that it was difficult to get an appointment but they were happy with the care provided.
NHS Choices	The practice had received a three out of five-star rating based on 44 ratings and 45 reviews. We noted mixed feedback across comments made during the last 12 months. Some comments described staff as friendly, approachable and caring whereas other comments highlighted concerns with regards to the manner of staff in areas.
Other	Feedback from a member of the patient participation group (PPG) and from two local care homes described a caring service. Feedback from the local care homes was very positive, some of the feedback complimented the GP on the care provided to patients with complex conditions, patients experiencing poor mental health and patients receiving end of life care.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4986	414	88	21.3%	1.76%

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)	84.2%	87.9%	89.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018)	83.9%	86.0%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	94.6%	95.4%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	81.1%	81.6%	83.8%	No statistical variation

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

Any additional evidence
• Results from the National GP Patient survey showed no statistical variation when compared with local and national averages. • We noted that NHS Choices comments had been responded to by members of the management team. Where issues were highlighted with regards to manner of staff, this was addressed and reflected on through staff meetings and training; including training in customer services. • The practice conducted an in house survey and provided evidence from the March 2018 survey

as part of our inspection. A total of 75 surveys were provided to patients, 33 (44%) were completed. Results highlighted that all respondents were satisfied with the service based on their overall experience and their engagement and interactions with the reception team.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: • We saw that the practice made use of and signposted patients to access support through local social prescribing schemes.	

Source	Feedback
CQC Comment Cards	Comments cards highlighted that patients felt involved in the decisions about their care and treatment.

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)	87.1%	92.8%	93.5%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: N/A	

Carers	Narrative
Percentage and number of carers identified.	There were 44 carers on the practices register, this was 1% of the practices population.
How the practice supported carers.	There was a carers information available in the practice containing a range of supportive and signposting information. There was also information available for carers to take away. Carers were offered health checks, health screening and flu vaccinations. Carers were also signposted to carer support services and support through local social prescribing schemes.
How the practice supported recently bereaved patients.	Bereaved patients were initially contacted by the GP where agreed with the individual and where appropriate the practice sent letters of condolences to support recently bereaved patients. Patients were also signposted to support services for bereavement care.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: • Feedback from patients gathered through various formats during our inspection highlighted that patients felt their privacy and dignity was respected when attending the practice for appointments, examinations and treatment.	

Responsive Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y

Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	9am – 6.30pm
Tuesday	9am – 6.30pm
Wednesday	9am – 6.30pm
Thursday	9am – 6.30pm
Friday	9am – 6.30pm
Appointments available:	
Monday	9am – 1pm and from 2pm – 6pm
Tuesday	9am – 1pm and from 2pm – 6pm
Wednesday	9am – 1pm
Thursday	9am – 1pm and from 2pm – 6pm
Friday	9am – 1pm and from 2pm – 6pm

- Practice phone lines were open from 8.30am.
- During afternoons when appointments were closed, patients were diverted to BADGER who were contracted to provide in-hours telephone coverage for the practice. There was a GP on call available to deal with urgent appointment needs.
- Patients were also able to access evening and weekend appointments through an extended access Hub arrangement with another practice situated in the Stechford area (approximately 2.5 miles away from the practice). These appointments were available Monday to Friday from 6.30pm to 8pm and on Saturdays from 9am to 1pm. The extended hours service was advertised in the practice and on the practice website.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4986	414	88	21.3%	1.76%

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)	93.8%	94.5%	94.8%	No statistical variation

Older people — Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.

- In recognition of the religious and cultural observances of some patients, the GP would respond quickly to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice worked closely with their local care homes, clinicians conducted visits, completed regular reviews and offered additional support and advice where needed.
- The practice offered a home visiting phlebotomy service for those with enhanced needs and complex medical issues.

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

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Although there was some evidence to support that patients with long term conditions were reviewed in dedicated clinics, during our inspection we noted that in some areas this system was not fully effective to ensure that peoples needs were fully responded to. For instance where patients with hypertension where not effectively reviewed.

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

Findings

- We found there were some systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, however we found that there was no clear register in place for children at risk, vulnerable children and those at risk and on child protection registers.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice offered a range of services for families, children and young people which included six to eight week baby checks with the GP, post-natal reviews for mothers and childhood immunisations. In addition they housed a community midwife clinic which they had increased from one to two clinics a week due to popular uptake and attendance.

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

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- Patients were able to access evening and weekend appointments through an extended access Hub arrangement with another practice.

People whose circumstances make them vulnerable

Population group rating: Good

Findings
• The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode. • The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. Vulnerable patients, patients with a learning disability and those with complex care needs were offered longer appointments. • We noted that the practice had purchased two small sensory play toys for children with Autism to play and use whilst waiting for their appointments. These were purchased from a suggestion made by a child's mother, staff described how they were useful for stimulation, coping and calming for children with Autism. • The practice had a veterans register in place and allocated a lead member of staff within the practice to assist with the recognition of veterans. These patients were signposted to support services, there was also a veterans policy in place to support this. • Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings
• Priority appointments were allocated when necessary to those experiencing poor mental health. • Staff we spoke with had a good understanding of how to support patients with mental health needs and those patients living with dementia. • The practice was aware of support groups within the area and signposted their patients to these accordingly. • The practice worked with the local Dementia Information for Support for Carers (DISC) team in conjunction with their Patient Participation Group (PPG) to promote and signpost patients and carers to this service, this provided support and help to those caring for patients with Dementia, Alzheimer's and memory loss.

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and	Y

the urgency of the need for medical attention.	
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence: • The practice operated an effective system for managing home visit requests, each request was reviewed by a GP who contacted the patient/carer to triage and attend if appropriate.	

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)	62.1%	N/A	70.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	66.5%	63.1%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	60.8%	63.4%	65.9%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	67.6%	70.2%	74.4%	No statistical variation

Any additional evidence or comments
Results from the National Patient GP Survey highlighted no statistical variation with regards to accessing care and treatment. During our inspection members of the management team described and evidenced some of the changes implemented to improve access, these changes included the installation of a new telephone system in October 2018 which allowed for analysis of peak times to ensure there were enough staff on reception and answering telephone calls to meet demand. The system also allowed for call monitoring to help with customer service skills through staff reviews, learning and training.

Source	Feedback
CQC Comment Cards	Comment cards were mostly positive with regards to care and access to the service, one comment highlighted difficulties in getting an appointment.
NHS Choices	We noted mixed feedback across comments made during the last 12 months. Some comments highlighted issues in getting through on the phone and others highlighted limited availability of appointments.
Other	Feedback from a member of the patient participation group (PPG) and from two local care homes highlighted no issues in accessing the service.

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	8
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	1

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

Explanation of any answers and additional evidence:

- Information about how to make a complaint or raise concerns was available in the practice waiting area. There was a complaints policy and form in place which could be used to capture verbal and hand-written complaints.
- The practices complaints policy reflected NHS complaints guidelines and patients were also signposted to further support services in the event that they wished to gain additional advice or escalate their concerns further.
- Minutes of practice meetings demonstrated that complaints, outcomes, actions, learning and themes were discussed at practice meetings.

Examples of learning from complaints.

Complaint	Specific action taken
Complaint made regarding an intended same day appointment incorrectly booked for the next day.	An investigation was completed involving all parties involved. Records noted that the issue occurred due to human error, staff were reminded to ensure thorough checking of times and dates on booking appointments. An apology was provided to the complainant and records noted that the matter was resolved over the phone, a formal response with a further apology was provided thereafter also.
Complaint made regarding correspondence given to the wrong patient.	Records noted that the patient was informed by the other patient, that they had receipt of their correspondence. On identifying the matter the practice conducted an investigation. The issue had occurred due to a mistake made by a member of the reception team, a formal apology was provided to those involved. To prevent recurrence the practice refreshed on the principles of General Data Protection Regulation (GDPR) as part of their learning process.

Well-led Rating: Inadequate

Leadership capacity and capability

Leaders could not fully 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.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y

Explanation of any answers and additional evidence:

- Although staff reported that leaders were visible and approachable, our review of the practices appointment system noted occasions when there were only nurses in clinic and there was no evidence provided by the practice to demonstrate a regular review of their nurses such as through formal clinical supervision or peer review.
- Furthermore, during our inspection we identified instances where a member of the nursing team had acted out of scope by signing and issuing Statement of Fitness for Work notes (also known as fit notes), these notes can only legally be issued by a GP. This was found as some members of staff described fit notes as part of the nurses role, we fed this back to members of the management team as part of the inspection however there was no evidence to indicate that this had been identified until the point of our inspection and therefore highlighted a lack of oversight by practice leaders.
- Following our inspection the practice provided assurance to confirm that patients who had been issued with a fit note by any persons other than a GP had been notified and were called to the practice to collect their re-issued fit notes; this was in response to our request for assurance.
- As part of our inspection we discussed the Registered Manager arrangements and we were informed that the Registered Manager had not been in the country for a while, the Registered Manager was also registered with CQC as a GP partner and listed on the practice website as such however members of the management team confirmed during our inspection that although they had access to the individual via telephone they were not visible nor currently based at the practice as a member of the team.

Vision and strategy

The practice had a vision and strategy in place to provide high quality sustainable care.

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

There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y

Explanation of any answers and additional evidence:

- The practices vision, in summary, was to offer the best quality care to their patients, working well together as a practice and through effective collaboration with colleagues.
- There was a business plan in place which was reviewed to monitor progress of delivery. We saw evidence of the business plan during our inspection, the plan noted that it was completed by the GP partners and practice team.
- As the practice was yet to join a Primary Care Network, this was a target in terms of joining and working collaboratively by February 2020.
- Members of the management team explained that they were hoping to further expand the clinical team following successful recruitment of the Healthcare Assistant and Advanced Nurse Practitioner within the previous 12 months; they were in the process of trying to recruit a new GP partner as part of their practice sustainability and planning.

Culture

The practice had a culture which drove high quality sustainable care in some areas, however this was not demonstrated in all areas during our inspection.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
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.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Partial
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:

- Although our review of the practices significant events and complaints showed evidence of compliance with the requirements of the duty of candour, during our inspection we received conflicting information with regards to the scope of a role within the nursing team; specifically the evidence found thereafter did not promote a culture of candour, openness and honesty at all levels.

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

Source	Feedback
Interviews with staff	Staff described the practice as a positive environment in which to work. Staff expressed that they were confident to raise concerns and to make suggestions at work. Management described the team as hard working and confirmed that they felt valued and supported in their role.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Partial

Explanation of any answers and additional evidence:

- During our inspection we found gaps in the governance and oversight of various systems to ensure that they were operating safely and effectively.
- This included gaps in child safeguarding systems, recruitment checks, untimely reviewing of urgent pathology results, lack of evidence to support formal clinical supervision in areas, overdue medicines reviews and not following certain clinical guidelines.

Managing risks, issues and performance

The practice did not always have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
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.	Y

Explanation of any answers and additional evidence:

- During our inspection we found gaps in the arrangements for identifying and managing risks, for instance it was at the point of our inspection where we identified gaps in the practices system for managing safety alerts and we identified an issue where a member of the clinical team had acted outside the scope of their role. The practice could not demonstrate effective oversight of their systems, processes and risks in some areas.

Appropriate and accurate information

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

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

Explanation of any answers and additional evidence:

- We found some evidence highlighting that information was not always accurate and managed in a timely way during our inspection. For example, there was no clear child protection register in place for children at risk and failed attendance of children's appointments in secondary care were not effectively captured on the patient record system.
- The arrangements for identifying, managing and mitigating risks were not operating effectively across certain areas, such as with regards to safety alerts.
- In some areas we found gaps in the practices systems and processes to keep clinicians up to date with current guidelines.
- During our inspection we were informed that the Registered Manager had not been in the country for a while, however the practice had failed to notify CQC of this absence as part of the CQC statutory notifications process; this met the criteria for notification because the absence was longer than 28 days. In addition, we found that the practice was not registered with the Care Quality Commission (CQC) to deliver specific services under the appropriate regulated activity of Maternity and Midwifery Services.

Engagement with patients, the public, staff and external partners

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

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

Explanation of any answers and additional evidence:
We saw evidence of regular meetings happening within the practice where staff could contribute towards the planning and delivery of services.

Feedback from Patient Participation Group.

Feedback
We spoke with a member of the Patient Participation Group (PPG) during our inspection, they noted that they met as a group on a regular basis and that they felt involved in the practice. The PPG helped to facilitate a patient education event with the practice and the local Dementia Information for Support for

Carers (DISC), this provided support and help to those caring for patients with Dementia, Alzheimer's and memory loss.

Continuous improvement and innovation

There were gaps in the evidence of systems and processes for learning, continuous improvement and innovation.

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

Explanation of any answers and additional evidence:

Whilst we saw some examples of shared learning and improvements made, in some areas we found that the approach was not fully effective. For instance, we noted a theme highlighting that in some areas, staff were not up to date with current guidelines. We saw that a similar issue was identified from a significant event dated 9 May 2019 whereby prescribing guidelines were not followed in a particular case and we found ongoing similar issues of guidelines not followed at the point of our inspection.

Examples of continuous learning and improvement
• The practice had engaged with the cancer research team at the Heart of England Trust to improve their bowel cancer screening rates. We also noted an improvement in childhood immunisation uptake for primary vaccinations and Pneumococcal boosters; these sources of data were both unverified and unpublished. • The practice had improved their policy management system and were actively utilising the GPTeamNet system which was used to support the management of policies, record keeping, training management and governance in various areas.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

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

The following language is used for showing variation:

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

Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

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

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