

Care Quality Commission

Inspection Evidence Table

FMC Health Solutions Limited (1-554206624)

Inspection date: 18 September 2019

Date of data download: 11 September 2019

Overall rating: Good

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

Safe

Rating: Good

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">Staff had received chaperone training, and the practice planned to deliver additional training to newly recruited members of the practice team. Practice procedure was for both the clinician and the chaperone to record chaperone usage on the patient notes.Key policies and documents were available on the practice IT system. We were told that the	

Safeguarding	Y/N/Partial
<p>policies and procedures had recently been revised and reissued.</p> <ul style="list-style-type: none"> • DBS checks were mandatory for all staff, and checks were made to ensure that checks were made on the DBS status of all locum and agency staff. • The safeguarding lead had monthly meetings with other health and care professionals to discuss at risk patients. Vulnerable patients were also discussed at regular in-house clinical meetings. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	No
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff immunity checks were not comprehensive and did not include an assessment of MMR and Varicella (chickenpox) status for appropriate staff. • We saw that staff personnel files contained details of checks made with regard to the registration of clinical staff. Recruitment and personnel files were detailed and well ordered. 	

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: 23 July 2019	Yes
There was a record of equipment calibration. Date of last calibration: 22 and 23 July 2019	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: February 2019	Yes
There was a log of fire drills. Date of last drill: 11 September 2019	Yes
There was a record of fire alarm checks. Date of last check: 9 September 2019	Partial
There was a record of fire training for staff. Date of last training: 16/07/2019	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 10 May 2019	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The findings from the latest fire evacuation drill had been analysed and actions put in place to make improvements. This included the provision of a staff in/out board to track persons in the practice. Checks on the fire alarm had been made. However, at times there were gaps of between six to seven weeks between checks been carried out. BS5839 Part 1: Code of practice for design, installation, commissioning and maintenance of systems in non-domestic premises is a standard published by the British Standards Institution gives guidance to test systems on a weekly basis. We were informed this lapse had been due to an organisational oversight during a period of staff absence. We were informed that this issue had now been rectified. A fire risk assessment of the two practices operating within the building had been completed in May 2019. It had identified no immediate risks but had made a number of recommendations which the practice was putting into place. This included increasing the numbers of staff acting as fire marshals. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out.	Yes

Date of last assessment: 21/03/2019	
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: April 2018.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Risk assessments were comprehensive and included themes such as lone working. • The practice had developed a standard operating procedure for the control of substances hazardous to health (COSHH). This had been updated and reissued on 12 September 2019. • Both practices operating within the building had received a Legionella risk assessment which was carried out on 16 September 2019. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control (IPC).	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: July 2019	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• In the last externally administered IPC audit, the practice had achieved a compliance rate of 92%. We saw that areas highlighted by the audit for improvement had been acted upon.• The IPC policy had been updated in September 2019.	

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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• As the practice worked as part of a larger provider, Health Care First Partnership, they were able to manage periods of staff absence and high demand. Locum and agency staff usage was limited.	

- Clinical templates in use within the practice linked automatically to national guidance.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice reported that there were no summarising or correspondence back logs. A dedicated team of staff undertook summarising and correspondence tasks.• The use of a common IT system allowed the practice to share information with other health and care professionals, such as community nursing staff• The practice had a centralised point for incoming test results, and processes were in place for the clinical assessment of these when required.	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.17	1.05	0.87	Significant Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2018 to 30/06/2019) (NHSBSA)	5.3%	6.3%	8.6%	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 (01/01/2019 to 30/06/2019) (NHSBSA)	7.89	5.81	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	1.75	2.56	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about	Yes

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had developed a protocol for the management and monitoring of patients in receipt of high-risk medication. • The practice had appointed a GP prescribing lead who also acted as the CCG medicines prescribing lead. We saw that overall prescribing, including antibiotic prescribing, was either in line with or lower than local and national levels. • The practice had a dedicated administration team who dealt with prescription requests. This team had the support of a pharmacy technician when required. • Blank prescriptions were closely monitored, and procedures were in place for their safe and secure storage. • The practice had information governance processes in place regarding remote and online prescribing. • Practice prescribing was supported by use of an IT decision tool. • The practice carried a limited number of essential emergency medicines. However, there was no formal risk assessment to support stocking decisions, such as the decision not to stock medication for the treatment of epilepsy seizures. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	Zero
Number of events that required action:	Zero
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The discussion of any significant events was a standing item for clinical and practice meetings. We were told that any learning from events such as significant events and complaints would be shared with staff via minutes of these meetings and the weekly staff bulletin.• The practice had formal notification procedures in place to inform external partners and other agencies of reportable incidents.	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice outlined fully their procedure for the receipt, analysis and actioning of patient safety alerts. There was a dissemination process for communicating alerts to clinical staff.	

Effective

Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Clinical templates in use within the practice record system linked automatically to national guidance. Changes in guidance were discussed at the regular team clinical meetings. New guidance was communicated to staff via direct emails, through attendance at team meetings, dissemination of team meeting minutes and via the staff bulletin. 	

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) (01/07/2018 to 30/06/2019) (NHSBSA)	1.42	0.86	0.75	Tending towards variation (negative)

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe

frailty. Those identified received a full assessment of their physical, mental and social needs.

- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients aged over 75 years had a named GP.
- Older patients were supported to make appointments when they experienced difficulties.
- Repeat prescription support was considered for patients with specific needs.
- The practice signposted patients to the Department of Work and Pensions for advice and support when need was identified.
- The practice offered a clinician call-back service. Patients contacted the practice and were triaged by trained staff. Patients identified as being in need were then placed on a clinician call-back list and contacted later in the day.
- Home visits were supported by the practice community nurse practitioners from the practice.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GPs and other clinicians worked with related health and care professionals to deliver a coordinated package of care. When appropriate, multi-condition reviews were available. An in-house pharmacy team was able to support medication reviews.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. For example, the practice had access to a specialist diabetic nurse and could support the needs of patients with more complex needs.
- The practice worked with secondary care providers and hosted a diabetes support clinic for patients with complex needs. In addition, the practice had linked into the community heart failure nurse to improve support for patients.
- The practice hosted a drop-in phlebotomy clinic which was more convenient for patients.
- The practice utilised e-consultations with secondary care services.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with Chronic Obstructive Pulmonary Disease (COPD) were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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) <small>(QOF)</small>	84.2%	78.4%	78.8%	No statistical variation
Exception rate (number of exceptions).	14.6% (27)	10.6%	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) <small>(QOF)</small>	71.7%	78.2%	77.7%	No statistical variation
Exception rate (number of exceptions).	17.8% (33)	7.6%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	92.5%	84.1%	80.1%	Variation (positive)
Exception rate (number of exceptions).	20.5% (38)	11.8%	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) <small>(QOF)</small>	84.2%	83.6%	76.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	10.2% (21)	11.2%	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) <small>(QOF)</small>	96.6%	91.2%	89.7%	Tending towards variation (positive)
Exception rate (number of exceptions).	14.6% (15)	10.7%	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)	83.9%	82.9%	82.6%	No statistical variation
Exception rate (number of exceptions).	7.0% (35)	3.4%	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)	88.1%	91.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	5.5%	6.7%	N/A

Any additional evidence or comments

- We discussed areas of higher than average exception reporting with the practice. They told us that they felt that this was in part driven by numbers of patients who were being treated for long-term conditions by secondary care, and therefore had received reviews and checks via these providers, rather than at the practice. The practice had exception reporting procedures in place, and we were told this included noting the reason to exception report within the patient record.
- Higher than average Hypnotic prescribing had been recognised by the practice. Historically the practice had a higher than average prescribing rate which was driven by local need, and via shared care services which they delivered. In response to this they had put in place measures to reduce prescribing and over a three-year period prescribing trends had shown an overall reduction.

Families, children and young people

Population group rating: Good

Findings

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Family planning skills had been enhanced within the practice. Via working with their wider organisational partners patients were able to access services such as contraceptive implants at other local practices.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.
- The practice had received local Young Person's accreditation for the delivery of services and health information to younger age groups.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	14	15	93.3%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	44	46	95.7%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	44	46	95.7%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	44	46	95.7%	Met 95% WHO based target

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information:
<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice offered a catch-up programme for students aged 17 and above for MMR and Meningitis C vaccination.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery. In addition, the practice offered additional services such as telephone triage and telephone appointments to patients.
- Patients could access extended hours services in the evening and at weekends via their local confederation. As well as urgent appointments this service also included planned care appointments and reviews.

- Working with Health Care First Partnership patients could access services at five other locations, this included the co-located Queen Street Surgery. In addition, by working at scale with the partnership, patients were able to access a wider range of services such as contraceptive implants.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (PHE)	69.9%	N/A	N/A	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	63.8%	69.5%	69.9%	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)	48.8%	57.2%	54.4%	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)	50.0%	65.8%	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)	40.0%	48.1%	51.9%	No statistical variation

Any additional evidence or comments

- The practice recognised that their cervical screening performance was below the 80% target. To improve this, the practice had signed up to a local CCG initiative to raise participation. Actions included proactively contacting patients who had not attended for a screening. In addition, as part of their working at scale arrangements with Health Care First Partnership, patients were able to access screening at other locations. This initiative also included seeking to raise breast and bowel cancer screening rates. For example, patients were sent text messages to encourage them to take part in the bowel screening programme.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. The practice held regular meetings with other health

and care providers to discuss the needs of palliative care patients.

- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice had been accredited under the local 'Safer Places' scheme (The Safer Places Scheme seeks to offer support and be a safe haven for vulnerable people when they are away outside their own home and may be in difficulties).
- The practice had appointed a dedicated Veterans health lead and was starting the engagement process to support this work. The practice had received accreditation for this work and were the first practice in the CCG area to have received this.
- The practice offered a shared care medication service for identified patients.
- Patients with learning disabilities or other disabilities were identified and care planned around their needs. These patients could access specific health checks.
- The practice offered support to carers, and via Health Care First Partnership carers could access carers events held at other locations. These included carers support events and regular informal meetings.
- In addition, Health Care First Partnership (including Park View Surgery) were piloting online consultations which could be useful for vulnerable patients such as those with a hearing impairment. They were also involved in a national pilot for carers proxy access (proxy access allows a parent, relative or carer to manage online services on behalf of another patient. Depending on the level of access required, the proxy user would be able to book appointments for the patient, order repeat medication and access their medical record).
- The practice was exploring registration status as a "Homeless Friendly Practice".

People experiencing poor mental health (including people with dementia)

Population group rating: **Good**

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. This approach was supported by the telephone triage service which was able to rapidly identify patients possibly at risk.
- 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.
- Staff had received dementia awareness training, and additional training was due to be carried out in the near future.
- Patients with poor mental health, including dementia, were referred to appropriate services.

- The practice offered call back assessments for these patients and they were prioritised when necessary.

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)	92.3%	91.1%	89.5%	No statistical variation
Exception rate (number of exceptions).	7.1% (1)	12.2%	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)	92.3%	90.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	7.1% (1)	12.5%	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)	100.0%	83.7%	83.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	37.5% (3)	7.1%	6.6%	N/A

Any additional evidence or comments

- Exception reporting for dementia care planning was high at 37.5%, however this was due to being influenced statistically by the low number of total patients on the dementia register (eight overall). The practice operating procedure with regard to exception reporting required the decision to exception report to be noted in the clinical record. Exceptions were only made after repeated invitations to patients and or carers to attend for reviews.

Monitoring care and treatment

The practice had a participated in quality improvement activity and reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	531.1	539.7	537.5
Overall QOF score (as a percentage of maximum)	95.0%	96.5%	96.2%
Overall QOF exception reporting (all domains)	7.6%	5.4%	5.8%

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

Quality improvement activity was targeted at the areas where there were concerns.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

- An audit into the prescribing of an anti-rheumatic medication and the associated risks of ocular toxicity had identified the need to ensure that patients were in need of an annual eye examination.
- An audit into QOF depression performance had identified a number of issues which included coding and missed patients. Actions had been taken as a result of this audit.

Any additional evidence or comments

- Working as part of their Primary Care Network the practice had identified local priorities which included mental health, COPD and pre-diabetes.
 - The clinical audits we saw showed that previous performance had been measured and recommendations for necessary improvements had been made. However, these audits had not been subject to re-audit, and therefore it was not possible to see if these recommendations had led to actual improvements. In addition:
 - Some of the clinical audits lacked detail.
 - We failed to see any evidence that an audit programme had been developed which was influenced by local need.
 - Audits were not specific to FMC Health Solutions Limited, and included other locations associated with Health Care First Partnership.
- We discussed this with the practice. They told us, and sent us further evidence which showed that the practice, working with Health Care First Partnership had:
- Developed a detailed clinical audit template and data collection tool.
 - Planned to repeat audits in order to track effectiveness.
 - Would in future audits look to disassociate data to identify individual practice performance.
- The service had, using guidance, produced their own service standards.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	No
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We saw that staff training was monitored and that mandatory training had been completed. At the time of inspection, a new training and development programme was being developed with Health Care First Partnership. At the time of inspection, the induction programme for Health Care Assistants did not include the completion of the Care Certificate. The practice was aware of this and this was in the process of being introduced. Annual appraisals were undertaken on an annual basis during September and October. We saw that members of staff had been supported to attain additional skills and qualifications. Advanced Nurse Practitioners told us they were well supported by the practice and received mentoring and guidance on an on-going basis. 	

Coordinating care and treatment

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

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

(QOF)	
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice held regular multidisciplinary meetings with other health and care professionals to discuss vulnerable patients and those with complex needs. 	

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice was able to refer and signpost patients to external stakeholders for services such as smoking cessation, weight management and nutritional advice. Reception staff had received care navigation training and were able to guide patients to more appropriate and accessible services. 	

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) <small>(QOF)</small>	92.8%	95.4%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.4% (3)	0.6%	0.8%	N/A

Any additional evidence or comments

- Care planning for patients with long-term conditions included discussions about lifestyle factors.

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The usual practice procedure was verbal consent, unless a procedure was more invasive such as minor surgery or the fitting of implants when written consent would be required.• We saw that the practice had on display advice for staff regarding consent and the Mental Capacity Act 2005(as revised).	

Well-led

Rating: Good

At the previous inspection on 15 September 2015 the practice was rated as outstanding for providing well led services. Following this inspection, we have rated the practice as good. This is because initiatives and practices that were previously regarded as innovative or unusual may no longer be so.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders could 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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice, working with Health Care First Partnership had developed new management structures based on:<ul style="list-style-type: none">○ Governance.○ People – these included joint clinical meetings, nursing team meetings and training events.○ New developments – these included a developing quality group which was tasked with quality assurance and performance monitoring oversight.• Staff we received feedback from said that the practice management team was approachable and that they worked closely as a team.	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence:	

- The practice had a five-year business plan (2019-2024) in place and was aware of key challenges such as demand management, finance and recruitment. This was to be monitored via the newly developed governance structures.
- Staff we received feedback from told us that they understood the vision and values of the practice, and said they saw their roles as to provide a high-quality service to patients.
- The practice had developed a poster for display in the practice which clearly outlined their mission statement and values.

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The leadership team explained to us how they would support staff improve performance when this was recognised as being required. The practice had appointed a senior member of staff to the role of Freedom to Speak Up Guardian, they had also recently reviewed and reissued their Whistleblowing Policy in September 2019. The practice told us that the immediate resolution of patient complaints and concerns was seen as a priority. Files we saw showed that complaints had been investigated thoroughly and that these were also discussed at team meetings. The practice had developed "Shine a Light" which recognised individual and team performance and improvement initiatives. The practice had held a large team building event in the summer of 2019 in conjunction with Health Care First Partnership. The practice and the wider Health Care First Partnership was accredited as a training practice. At the time of inspection Health Care First Partnership had eight GP Registrars and one Foundation Year Two GP working across the range of their locations. 	

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

Source	Feedback
Staff	Staff gave us feedback which said that their relationships with managers were good, and that both clinical and non-clinical teams worked well together and supported each other.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We saw that practice governance had been reviewed and that new structures had been introduced. This involved the practice working with Health Care First Partnership. The structure included: <ul style="list-style-type: none"> ○ Governance Board – made up of members from FMC Health Solutions Limited and Health Care First Partnership which met once every six weeks. ○ Executive Team – composed of three members (one from the FMC Health Solutions Limited), the chief nursing officer, HR and Operations Manager and the practice Business Manager which met weekly. Their remit was to manage strategy delivery, oversee performance and drive developments. ○ Operations Team – composed of staff from a number of teams both clinical and non-clinical. Their remit was operational delivery and capacity and demand management. • All staff we spoke with on the day were clear about the roles that they had to play within the practice. 	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice, working with Health Care First Partnership had established or were in the process of, establishing structures to regularly review and monitor systems and performance. This included a newly developed Quality Group and a regular Finance Team meeting. The practice had a business continuity plan in place and working with larger Health Care First Partnership had added resilience. Clinical and internal audit was in place within the practice. However, it was noted that there did not appear to be a detailed programme of audits, targeted to the specific needs of local patients. Many audits were driven by external sources such as the CCG. Whilst some audits we examined were detailed, some audits lacked detail and depth. The practice had signed up to the Productive General Practice Programme (an organisation-wide change programme, developed with general practice staff, which supports general practices in promoting internal efficiencies, while maintaining quality of care). 	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We saw that specific resources had been allocated to the collection, collation, analysis and 	

management of data. This included performance data.

If the practice offered online services:

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group (PPG).	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Working with the wider Health Care First Partnership the practice had formed a joint Patient Participation Group. This work was supported by a newly developed patient liaison meeting which met on a weekly basis and which had a remit to analyse and monitor and propose actions in relation to patient and stakeholder feedback.Staff informed us that they were kept well informed and were able to give feedback to the practice management team.We heard that following feedback the appraisal system had been refined and improved.	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none">During the inspection we did not have the opportunity to speak with a member of the PPG. We did however see minutes of previous PPG meetings which showed that the practice actively discussed services, developments and took feedback relating to Park View Surgery.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">We saw that the practice supported the development of staff to improve skills and operational efficiency.The practice had effective communication methods in place to share key messages and learning. This included via structured minuted meetings and a weekly bulletin to all staff.	

• Examples of continuous learning and improvement

- The practice had signed up for the GP 'Quick Start' Programme (an on-site, hands-on, short term support package for practices. It aims to help practices release time for care through new improved ways of working).
- The practice and Health Care First Partnership had developed new management structures to drive quality improvement and innovation.
- The practice was involved in the development of their Primary Care Network.

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.