Care Quality Commission

Inspection Evidence Table

Kidderminster Medical Centre (1-6095984332)

Inspection date: 11 October 2019

Date of data download: 18 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
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
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: All members of staff we spoke with during the inspection were able to describe situations when they had	

Safeguarding	Y/N/Partial
raised safeguarding concerns following agreed protocols Safeguarding examples were shared across the organisation and discussed at monthly meetings with the board of the Wyre Forest Health Partnership during the quality risk and performance committee. We saw that safeguarding meetings were held every six weeks with the site manager, GP, health visitor, school nurse and safeguarding midwife. There was a named administrator who followed up on all patients who did not attend appointments.	

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.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Explanation of any answers and additional evidence: During the inspection we saw a range of policies with regards to recruitment including a comprehensive induction policy and a new staff performance review policy. This ensured that new members of staff and their line managers had regular review meetings.	

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:10/10/2019	Yes
There was a record of equipment calibration. Date of last calibration: 10/01/2019	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: 10/10/2019	Yes
There was a log of fire drills. Date of last drill: 10/10/2019	Yes
There was a record of fire alarm checks. Date of last check: 10/10/2019	Yes
There was a record of fire training for staff. Date of last training: There were different dates documented for fire training on the training matrix we reviewed during the inspection.	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 2 July 2019	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: The external fire risk assessment showed that there were no outstanding actions with regards to fire safety at the practice. The practice also completed an emergency lighting check on a monthly basis.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: August 2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Yes
Explanation of any answers and additional evidence: The practice had carried a number of risk assessments such as a Legionella risk assessment which was carried out on 7 October 2019. We saw that the Health and Safety policy had been updated in July 2019.	

The practice had carried out a risk assessment when two wheelchairs had gone missing from the practice. It was decided that it was essential that these were replaced in order to help patients with restricted mobility from the reception areas to consultation rooms. This was done immediately.

The practice had held some in house training with all staff regarding lone-working to ensure all risks were identified and addressed.

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.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:5 August 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: As a result of the last external infection control audit which was carried out by the Clinical Commissioning Group it was identified that new staff needed to complete infection control training during their induction. This was immediately incorporated into the induction policy.	

Risks to patients

There were adequate 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: All members of staff we spoke with during the inspection had received sepsis training. They were able to give examples of when they had pressed the panic buttons and clinicians had come to help them straight away.	

Posters about sepsis were displayed on the walls at the practice. We saw that sepsis management was discussed at the practice meetings.

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:	

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)	1.05	1.01	0.87	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). (01/07/2018 to 30/06/2019) (NHSBSA)	7.9%	7.7%	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)	5.77	5.32	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)	1.34	1.58	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).	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.	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.	NA
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes

Explanation of any answers and additional evidence:

During the inspection we found that one of the Patient Group Directions had not been signed. This was rectified immediately.

We found that the vaccines fridge thermometer was not always reset after each reading. No medicines had been compromised as a result of this. The practice had a comprehensive medicines list but the list did not show the expiry dates of the medicines. We did not find any medicines which had expired during our inspection. This process had been changed since the inspection.

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:	28
Number of events that required action:	All
Explanation of any answers and additional evidence: Significant events were discussed at weekly meetings. The practice had a comprehensive template with an action plan for all significant events. We could see that there was practice-wide sharing and learning from the significant events. Significant events were also taken to the Wyre Forest Health Partnership Board for discussion at the monthly quality, risk and performance committee.	

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

Event	Specific action taken
A patient had a minor operation at the practice. The histology was sent to the lab in line with the practice protocol. The patient had not heard results of the biopsy after two months.	The GP had sent himself a task on EMIS to chase result after a month. However, the GP went off sick and no other staff member had access to his own tasks. The practice was unaware that this needed chasing up. There is a process in place across the Wyre Forest Health Partnership for ensuring results are received and actioned appropriately with follow up by the duty doctor. This was sent out to all clinicians to remind them of the process.
A daughter dropped a sample into surgery. She was told the results would be discussed with her once the urine had been tested.	No contact from surgery so daughter called. The urine had not been tested and once located was found to suggest infection – patient had previously been diagnosed with an infection. The urine sample had been returned to reception and it was not clear why or how it came to be returned to reception once it had been tested by HCA. The process for following up after testing samples had not been followed on this occasion. Following this all healthcare assistants at the practice attended a learning session with the nurse to ensure everyone was aware of the correct procedure.

A prescription for Controlled Drugs (CDs) was reprinted at the request of reception due to the receptionist not being able to locate the original one.	The CD collection card had not been completed so it was unclear who had collected the prescription. GP issued another one. When patient went to the pharmacy to cash the prescription they already had one in her name and she ended up with two prescriptions of CDs. The practice changed its procedure to ensure all prescriptions for CDs were sent electronically so patients did not have to collect the script in person. The patient risk was assessed and there was not found to be any concerns regarding overuse of the medicine. A note was placed on the system that the patient had received two months' supply to prevent over ordering.

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: The practice had a comprehensive system for dealing with safety alerts. The Site Manager and the pharmacist received all the alerts. These were forwarded on to clinicians for action as required.	

Effective Rating: Good

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was 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:	

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)	0.84	0.59	0.75	No statistical variation

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 medicine 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.The practice were holding flu clinics on Saturday mornings.
- The practice had an enhanced service for care homes offering additional levels of support. Each home had a named GP for residents in the homes to access.

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 GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with 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) (QOF)	85.6%	83.6%	78.8%	No statistical variation
Exception rate (number of exceptions).	14.6% (135)	10.9%	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)	78.6%	79.3%	77.7%	No statistical variation
Exception rate (number of exceptions).	11.8% (109)	8.2%	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) (QOF)	90.9%	82.4%	80.1%	Variation (positive)
Exception rate (number of exceptions).	18.5% (171)	13.7%	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)	72.6%	75.9%	76.0%	No statistical variation
Exception rate (number of exceptions).	1.9% (20)	2.1%	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)	92.2%	91.2%	89.7%	No statistical variation
Exception rate (number of exceptions).	8.1% (27)	7.1%	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)	84.6%	86.5%	82.6%	No statistical variation
Exception rate (number of exceptions).	5.1% (119)	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)	98.3%	98.5%	90.0%	Variation (positive)
Exception rate (number of exceptions).	9.8% (25)	13.8%	6.7%	N/A

Any additional evidence or comments
During the inspection we checked exception reporting and noted that the practice were exception reporting appropriately.

Families, children and young people Population group rating: Good

Findings

- Childhood immunisation uptake rates were below 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.
- 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.
- 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.

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)	126	141	89.4%	Below 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)	128	150	85.3%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	127	150	84.7%	Below 90% minimum
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)	128	150	85.3%	Below 90% minimum

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

In order to increase the uptake of childhood immunisations the practice tried drop in clinics, texting and using social media to encourage parents to immunise children. This did not increase uptake.

After reviewing the system, the outcome was that a named nurse and named administrator would engage with families who did not attend. They phoned families the day before an appointment to remind them and again if they did not attend. This has reduced the DNA rate and increased the uptake.

The practice shared data from their quality and risk report which showed that there had been an increase in the uptake of childhood immunisations from 85% in April 2019 to 92% in September 2019.

The staff have tried to think of family friendly ways to encourage parents to attend for immunisations. During the previous half term they had held a drop-in clinic which had seen a boost in uptake of immunisations. During the inspection we saw a poster for the forthcoming October half term where they had introduced a Halloween colouring competition, with staff in fancy dress to encourage uptake of the childhood immunisations.

Working age people (including those recently retired and students)

Population group rating: Good

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 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.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- The practice provided early morning and evening telephone calls bookable online as well as offering online access and were trialling video consultations.

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) (Public Health England)	70.5%	N/A	N/A	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) **(PHE)**	77.0%	78.6%	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)**	57.7%	61.5%	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)**	77.3%	81.1%	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)	63.4%	56.3%	51.9%	No statistical variation

Any additional evidence or comments

The practice were following up on patients who did not attend for their cervical screening in order to improve uptake. This was done by letter and then followed up with a phone call.

The practice had held a breast screening event to raise awareness and increase uptake. The practice shared unverified data which showed a gradual increase from 2017 where uptake was 69% to 2018 where it was 77%.

People whose circumstances make

Population group rating: Good

them vulnerable

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 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 reviewed young patients at local residential homes.

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.
- 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.
- All staff had received dementia training in the last 12 months.

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)	94.3%	93.8%	89.5%	No statistical variation
Exception rate (number of exceptions).	7.9% (9)	8.8%	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)	98.2%	94.5%	90.0%	Tending towards variation (positive)
Exception rate (number of exceptions).	4.4% (5)	6.8%	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)	79.3%	87.6%	83.0%	No statistical variation
Exception rate (number of exceptions).	7.4% (7)	5.3%	6.6%	N/A

Any additional evidence or comments

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	559.0	556.4	537.5
Overall QOF score (as a percentage of maximum)	100.0%	99.5%	96.2%
Overall QOF exception reporting (all domains)	6.1%	4.5%	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.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

past two years

The practice regularly carried out audits to improve outcomes for patients. During the inspection we reviewed two full audit cycles.

The practice had carried out an audit in the use of antipsychotic medicine in patients with dementia to ensure the medicine had been reviewed and to see whether there was evidence of a plan to stop the medicine. The audit showed that eight out of 11 patients had been reviewed appropriately and an attempt made to stop the medicine. The re-audit showed that all patients had been reviewed appropriately and there was a reduction in the number of patients with dementia on anti-psychotic medicines.

The practice had carried out an audit to check if patients on thyroxine were having blood tests in a timely manner. The first audit showed that only 60% of patients on thyroxine had their blood tests in a timely manner. The re-audit showed that 90% of patients had a reminder for their blood tests.

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.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	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: The practice was using staff in an effective way. The Advanced Practice physio was doing 90% of joint injections per week which meant a GP was able to free up one clinical session per week.	

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) (QOF)	Yes
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
Explanation of any answers and additional evidence:	

Helping patients to live healthier lives

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

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

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)	96.8%	96.2%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.9% (35)	0.6%	0.8%	N/A

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:	

Caring Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
Explanation of any answers and additional evidence: Prior to the inspection we spoke with both care homes which the practice looked after. They were positive about the care their residents received. Both care homes commented on how well the practice dealt with end of life care for their residents.	

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

Source	Feedback
Patients	During the inspection we saw letters and cards sent to the practice from patients. The letters and cards commented on the care delivered by the doctors and nurses. We spoke with a patient during the inspection who explained that a doctor would always call back on the same day and that if the situation was urgent then patients got seen sooner.
Interviews with staff	The staff we spoke with during the inspection commented on the caring nature of the GPs and management team at the practice. There were regular staff social events and staff worked together to raise funds for those in need.

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
13446	316	116	36.7%	0.86%

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 (01/01/2019 to 31/03/2019)	83.3%	89.3%	88.9%	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 (01/01/2019 to 31/03/2019)	78.3%	87.8%	87.4%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	91.8%	95.7%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	68.4%	85.7%	82.9%	Tending towards variation (negative)

Any additional evidence or comments
The practice had identified that patients were dissatisfied with change, perceived lack of continuity, seeing a different GP along with some GP sickness at the time. In order to overcome this the practice had invested in developing all staff and improved communication via social media. At the time of our inspection the practice reported that patient perception had started to shift positively. They had captured feedback from events assisted by the patient participation group such as coffee mornings and Saturday flu clinics. The practice had carried out a telephone survey in September 2019. The practice shared that 15 patients completed the survey and were happy with the improved telephone system. Each month the practice collated data to review how quickly phones were answered. In February 2019 the average wait time for the phone was just over three and a half minutes. By August 2019 the average wait for the phone was just under two minutes. The practice shared some feedback they had received in September 2019 on their social media page which was positive about the practice. The practice had increased the number of face to face appointments available via the extended hours access so that patients could be seen between the hours of 8am and 8pm.

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

Any additional evidence
The practice had carried out its own surveys with the help of the patient participation group. The feedback received was starting to improve at the time of our inspection.

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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence: Easy read leaflets were available with pictorial information. The practice leaflet was also available in yellow to make it easier for patients with dyslexia to read.	

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 (01/01/2019 to 31/03/2019)	92.3%	93.4%	93.4%	No statistical variation

Any additional evidence or comments

The results of the Friends and Family Test was as follows:

April 2019– 343 responses of which 293 (85%) would recommend the practice.
May 2019– 474 responses of which 410 (86%) would recommend the practice.
June 2019– 375 responses of which 328 (87%) would recommend the practice.
July 2019– 373 responses of which 323 (87%) would recommend the practice.
August 2019– 375 responses of which 331 (88%) would recommend the practice.
September 2019– 323 responses of which 285 (90%) would recommend the practice.

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

Carers	Narrative
Percentage and number of carers identified.	514 carers – 4%
How the practice supported carers (including young carers).	The practice had some carers leaflets in the waiting room with information about being a carer and information about support organisations. Information about carers is included in registration packs. The leaflets in the waiting room were rotated on a two-weekly basis.
How the practice supported recently bereaved patients.	The practice contacted bereaved families. This was sometimes by phone and sometimes in person depending on the circumstances. Condolence cards were also sent out to families following a bereavement.

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.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence: We saw that a room was available for patients to use if they were distressed in the waiting room.	

Responsive Rating: Requires Improvement

The practice has been rated requires improvement in responsive. The practice was not able to demonstrate that the measures they had taken in response to the areas of lower satisfaction highlighted in the patient survey had been effective.

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence:	

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
	The practice offered appointments to patients via the hub from 6.30 pm to 8.30 pm Monday to Thursday.

	The practice also opened two Saturday mornings per month from 8am to 11am.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
13446	316	116	36.7%	0.86%

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 (01/01/2019 to 31/03/2019)	98.6%	95.7%	94.5%	Tending towards variation (positive)

Any additional evidence or comments

Older people

Population group rating: Requires Improvement

Findings

- The practice has been rated requires improvement for responsive and this applies to all population groups.
- 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.
- The advanced nurse practitioner was employed to care for housebound patients and care home patients. This ensured continuity of care. She worked closely with GPs and attended MDT meetings.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients.
- The practice was working to improve social isolation and were developing social prescribing at the time of our inspection. This practice was the hub for social prescribing in the Wyre Forest partnership.
- The practice offered a named GP and designated administrator for patients receiving end of life care. The palliative care register was reviewed on a monthly basis. There were written care plans in the notes for palliative care patients and patient care preferences were communicated during MDT meetings and to out of hours services.
- The GPs worked with the clinical pharmacists to improve medicines management for patients

following discharge from hospital.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- The practice has been rated requires improvement for responsive and this applies to all population groups.
- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services. The clinical leads were involved in regular discussions of long-term disease management.
- 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.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.
- The practice had annual long-term condition checks for those on the long-term condition register with tailored recall and appointment times. Patients who did not engage were chased up.
- High risk drug monitoring, INR (blood clotting) testing for patients on warfarin and D-dimers for patients who might have a blood clot were performed at site. There was a central checking system in place to monitor the compliance.

Families, children and young people

Population group rating: Requires Improvement

Findings

- The practice has been rated requires improvement for responsive and this applies to all population groups.
- Additional nurse appointments were available until 7pm on a Monday for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice used the GP First system which meant that the GP would telephone patients. This provided some flexibility to take calls after the school day.
- The practice had a system whereby urgent slots were in red and all GPs had three per day on their appointment screen. Children under the age of one were triaged urgent so that clinicians could see at a glance and offer appointments for the same day.
- A range of appointments were available on site such as physiotherapy, women's health, contraception, mental health and drug and alcohol support.
- There was a named member of the administration team who was allocated to post-natal checks and to follow up on patients who did not attend.
- Families of military veterans were coded so that appropriate referrals were made.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice has been rated requires improvement for responsive and this applies to all population groups.
- 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.
- The practice was the host for extended access across Wyre Forest Partnership and could offer face to face appointments Monday to Thursday until 8.30pm and on two weekends a month.
- The practice communicated with patients using social media and text messaging.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- The practice has been rated requires improvement for responsive and this applies to all population groups.
- 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 such as homeless people and travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. The practice had tried to increase uptake with Saturday morning clinics but it had not worked due to lack of availability of carers on a Saturday.
- The practice had some patients on the register who had no fixed abode. They were coded appropriately and patients could use the practice address for post relating to health.
- The practice was a military veterans accredited practice. The practice kept a register of veterans so they could provide appropriate support and signposting. At the time of our inspection there were 42 patients on the register.
- Patients could receive drug and alcohol support twice a week at the practice. The practice was situated near to a site used by the local council to accommodate homeless people, including those with a history of substance misuse. As a result, the practice had arranged for a worker from a national charity to provide drug and alcohol support twice a week at the practice.
- When patients were attending outside of core hours there was a caretaker available to monitor car parking and to assure patients of safety during quiet times.
- The practice took part in a number of health engagement activities to raise awareness for patients such as jeans for genes day and dress down Friday to raise money for charity.
- All patients with learning disabilities have a named nurse and GP to support them. Easy read health form checks were available for patients.
- The practice had been authorised to issue food bank vouchers to vulnerable families.
- The practice was the hub for social prescribing and signposted patients as and when required.
- During the inspection we saw that the practice had carried out some work to accommodate transgender patients and ensured wishes were respected.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

- The practice has been rated requires improvement for responsive and this applies to all population groups.

- The practice were proud of their status as a dementia friendly site and they were working towards dementia accreditation. They had signs on the inside of toilet doors so patients suffering with dementia could find the exit when they got in.
- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed 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.

Timely access to the service

People were 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.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes
Explanation of any answers and additional evidence: Visits were triaged by a nurse or GP as required. Residential home visit requests were automatically added to the home visit list for the GPs to review.	

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 (01/01/2019 to 31/03/2019)	39.9%	N/A	68.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	46.1%	74.2%	67.4%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	53.0%	72.0%	64.7%	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 (01/01/2019 to 31/03/2019)	55.9%	79.8%	73.6%	Tending towards variation (negative)

Any additional evidence or comments
The practice was continually reviewing access and availability of appointments. We could see that this was discussed at practice meetings. We saw that the practice had posters for the range of appointments offered which included cervical screening, NHS health checks, warfarin monitoring and appointments to specialist services such as the drug and alcohol service. The practice had increased the amount of appointments which could be booked online in order to improve access. The practice offered patients the ability to request medical advice using the email service called Ask My

GP. This was monitored throughout the day and any incoming correspondence was triaged and patients were signposted to the most appropriate clinician.

During the inspection we spoke with a patient who said that phone access was getting better. The feedback we received from the PPG was positive about phone access. They had gathered feedback from patients at coffee mornings and during flu clinic.

The phone system at the practice was changed in January 2019 to provide a better experience when calling in. This meant that patients had a number in the queue and they could be diverted to the appropriate department. Staff were reviewing the number of calls in the queue and how long patients were waiting. Monthly data was sent to site managers after the Wyre Forest Partnership board reviewed this date. During the inspection we saw that in January there had been 10,500 calls and the average response time was three minutes. At the time of our inspection the practice was handling 11,500 calls per month and the majority were answered in under two minutes. The practice monitored this closely with a display board in the admin area to keep staff focussed on the average response times. Patients were informed if their appointment was running late. This was confirmed by patients we spoke with. The site manager was reviewing this to ensure reception staff were working at the busiest times of the week and altering their shift patterns and days of the week to respond to the demand.

All reception staff had received care navigation training at the time of our inspection in order to triage calls effectively.

If there were any problems with phone lines on a particular day this was shared on the practice's social media page to ensure transparency and understanding.

All of the reception team had received customer service training as part of the resilience funding obtained by the CCG to ensure smarter working and to improve access.

The team leader had received extra management training to support her to successfully manage the team and also to manage patients and reduce complaints.

The practice ran a weekly report to assess how many appointments were booked in advance. This gave them an idea of capacity available and allowed them to respond to need. For example, in May 2019 there were 224 pre-booked appointments compared to November 2019 where they had reduced the number to 104 pre-booked appointments over the following 6 weeks all of which were appropriately booked ahead. The practice were continuously reviewing access.

Source	Feedback
For example, NHS Choices	NHS choices had some poor reviews from patients from January 2019 with one-star ratings. This improved throughout the year to a number of five-star ratings.

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.	21
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Explanation of any answers and additional evidence:

The practice had faced some challenges with the merger of two practices. This had caused disruption, patients were not happy with changes and performance which generated more calls from patients to complain which made phone access worse. As well as addressing immediate issues such as access from the car park, the practice took stock of the situation and identified common themes of complaints such as appointments, lack of continuity, lack of communication. The practice reviewed their model of care, took on more ANPs and worked more efficiently. For example ANPs could prescribe. They also worked on communication via social media.

We saw that complaints were discussed at practice meetings. Complaints were also discussed at board level for the whole of the Wyre Forest Health Partnership at quality and risk meetings.

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient was seen by the advanced nurse practitioner and referred for physiotherapy. The advanced nurse practitioner did not put her referral though the correct process and it was not reviewed in the referrals meeting by the GPs.	It was identified that the referrals process was not explained to the advanced nurse practitioner during induction clearly enough. As a result, the procedure at the practice has changed and all new clinical staff spend time with the secretaries so that they can be shown the referral process.
A patient complaint that a nurse had been rude about their child's appearance during a consultation and had made comments about their weight which the family were offended by.	The practice investigated this complaint with the advanced nurse practitioner. She reflected and realised she could have dealt with the matter in a more sensitive way. She apologised to the family and this was accepted.

Well-led Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels

	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.	
Explanation of any answers and additional evidence: All staff we spoke with during the inspection told us they felt supported by the practice manager and GPs at the practice. The practice manager and GPs felt supported by the Wyre Forest Partnership board.	

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 clear vision and strategy to deliver high quality holistic care. Staff we spoke with during the inspection described the ethos of the practice as being caring, committed and working with integrity to making experiences for the patients and staff. We could see there was an ethos to learn from significant events and complaints. This learning was	

shared across the organisation.

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

Explanation of any answers and additional evidence:

The provider told us how they viewed the retention of quality staff as something very important, and so worked to be a flexible and supportive employer. For example, they told us how they had invested in developing their reception team in particular. As a result, GPs found that the reception team were able to provide them with good quality information about a patient's needs before the consultation began, which in turn improved the quality consultation. GPs told us they were able to work at other sites across the Wyre Forest Health Partnership to share learning, and GPs from other sites were also able to work at Kidderminster Medical Centre.

The practice displayed a supportive culture. Staff we spoke with felt proud to work at the practice.

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

Source	Feedback
Conversations with staff at the practice	We spoke with members of staff during the inspection and they spoke about a supportive environment with an open-door policy. There had been a lot of staff changes in the last couple of years with staff sickness. The staff felt supported and kept up to date throughout this.

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:

There was central governance at the Bewdley site of the Wyre Forest Health Partnership.

The site manager shared examples of when she had contacted other site managers if in need of extra specialist information. The site manager felt that help was always instigated from the Chief Executive Officer at The Wyre Forest Partnership and she felt able to contact anyone on the board for help and advice.

There was clear and effective communication at the practice. The practice had a range of meetings:

- Six weekly Gold Standard Framework Meetings with the lead GP, Macmillan nurse and District Nurse.
- Weekly meetings with the GP, PM and Deputy PM. There was a representative from each site at these meetings.
- Quarterly Away Day.

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.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: There was a comprehensive business continuity plan which was also stored electronically if people could not access the building for any reason. There was also a box that was kept with emergency contact number and torches which was transportable if required.	

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: The Wyre Forest had an effective IT system. When any member of staff made a change to policies and procedures other sites could see this instantly and comment as required.	

All meeting notes we reviewed were well documented and the IT system enabled staff to make comments as required.

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.	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:

The provider told us they aimed to get a military veteran on the board in order that views of this sector of patients could be represented.

The practice worked with the CCG and other practices in the Wyre Forest Partnership to improve outcomes for patients.

Feedback from Patient Participation Group (PPG)

Feedback
During the inspection we met with three members of the PPG. They met every four to six weeks and felt supported and valued by the practice. The PPG commented that if they raised something which required a GP's response this was always provided. The site manager and reception manager always attended the PPG meetings. A GP from the practice attended PPG meetings three or four times a year. The PPG had suggested about having a radar key for the disabled toilets. Following their suggestion, the practice implemented this straight away. This was communicated to patients by the website and by word of mouth. The PPG told us how they had worked with the practice to run coffee mornings at different times of the year, and had held three such events so far. They described these events and the Saturday morning flu clinics they had assisted at as an opportunity to gather feedback on an informal level from patients, which they were able to pass on to the practice. The PPG felt the practice were receptive to their ideas. The practice had raised £300 for charity and regularly supported fundraising events.

Continuous improvement and innovation

There was 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: Previous trainees had been recruited to work at the practice. One of the receptionists had asked for some additional responsibility. They had become in charge of post-natal bookings and follow up. Another site manager had requested additional management training and had progressed to be on the board of The Wyre Forest Partnership.	

Examples of continuous learning and improvement
The practice had a full educational programme for medical students and trainee GPs. We saw evidence of education meetings covering a wide range of updates and topics such as long-term disease management. The practice was looking at ways of improving. For example they had tried a Saturday morning clinic for patients with learning disabilities. They were developing child-friendly drop in clinics during half-term to try to improve childhood immunisations.

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.