

Care Quality Commission

Inspection Evidence Table

Forrester Street Medical Centre (1-5783196351)

Inspection date: 4 February 2020

Date of data download: 09 January 2020

Overall rating: Requires Improvement

We rated the practice as requires improvement overall because:

- Recruitment procedures were not being effectively implemented as not all of the required recruitment checks had been obtained prior to all staff starting employment or were available on file. Risk assessments had not been completed to mitigate any risks.
- The practice's performance for long-term conditions were significantly below the local and national averages, and targets for childhood immunisations and cervical cancer screening had not been met.
- Although improvements had been made, patients continued to report challenges with telephone access and getting appointments.
- There had been delays to completion of the planned alterations to the premises, which had only recently commenced.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19. The QOF data was collected in relation to the previous provider between April and September 2018 and for Modality Partnership between October 2018 and March 2019.

Safe Rating: Requires Improvement

At our previous comprehensive inspection on 11 July 2019 we rated safe inadequate and issued a warning notice in relation to safe care and treatment. This was because:

- The management of safety systems was not effective particularly in relation to safeguarding, staff training, employment checks and health and safety checks.
- The systems, processes and practice that helped to keep patients safe and safeguarded from abuse were insufficient.
- The system in place at the practice had not always ensured that all children who did not attend their appointment following referral to secondary care were appropriately monitored and followed up. Not all staff were aware of the practice safeguarding lead.
- The processes for managing information within the practice were not effective. Staff did not have the information they needed to deliver safe care and treatment due to the back log of administrative work.
- The process for monitoring patients' health in relation to the use of medicines prior to prescribing was not always being followed.

- Not all significant events were reported or investigated, and any learning that had been identified was not communicated effectively or embedded into practice.
- There was a lack of a systemic approach for ensuring patient safety alerts had been actioned.
- There was a lack of evidence of any sustained input regarding leadership at the practice by the provider following the takeover and merger of the three practices.

We carried out an announced inspection on 29 October 2019 to follow up on the warning notice issues and found that the provider had satisfactorily addressed the issues identified in the warning notice.

Although we found that improvements had been made at our comprehensive inspection in February 2020, the practice was rated as Requires Improvement for providing a safe service because:

- Recruitment procedures were not being effectively implemented as not all of the required recruitment checks had been obtained prior to starting employment or were on file. Risk assessments had not been completed to mitigate any risks.

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.	Partial
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: At our comprehensive inspection in July 2019, we found the practice could not demonstrate that all staff had received safeguarding training to an appropriate level or were aware of the practice's safeguarding leads. In addition, a system for following up children that failed to attend hospital appointments or frequently attended A&E was not in place.	

Safeguarding	Y/N/Partial
<p>During our follow up inspection in October 2019, we found that staff had received appropriate safeguarding training, been made aware of the practice's safeguarding leads and received a copy of the safeguarding policies. Posters were on display advising staff of the safeguarding leads and their contact details. Systems and protocols for following up children that failed to attend hospital appointments or frequently attended A&E had been implemented. The practice had also introduced weekly clinical meetings, which the health visitor attended once a month.</p>	
<p>We saw that all staff were provided with safeguarding training. Discussion took place regarding the intercollegiate guidance relating to safeguarding training. The practice was aware of the changes, and plans were in place for staff to complete the required level of training.</p>	
<p>At the comprehensive inspection In February 2020 we found that the systems and processes had become further embedded into practice. Staff spoken with during the inspection were aware of the safeguarding lead for the practice and knew where to locate the relevant policies and procedures. Contact details for children and adult safeguarding teams was accessible to staff in consultation rooms. Safeguarding was a standing agenda item at clinical and practice meetings.</p>	
<p>We saw the system to follow up failed hospital appointments was effective. We saw an example of how the practice had followed up a vulnerable patient who had failed to attend a hospital appointment. The GP had visited the patient at home but had been unable to resolve the issues and had subsequently escalated their concerns to the adult safeguarding team and specialist nurse.</p>	
<p>The practice continued to invite health visitors to clinical meetings once a month, although they were often only able to attend every three months. Children non-attendance at A&E, secondary care appointments or childhood immunisations were monitored, reviewed and where appropriate recalled. All safeguarding patients were electronically read coded and flagged on the practice clinical system.</p>	

Recruitment systems	Y/N/Partial
<p>Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).</p>	<p>Partial</p>
<p>Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.</p>	<p>Yes</p>
<p>There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.</p>	<p>Yes</p>
<p>Explanation of any answers and additional evidence:</p> <p>At our comprehensive inspection in July 2019, we found that recruitment procedures did not operate effectively. During our follow up inspection in October 2019 we reviewed the files of two newly recruited members of staff and a locum GP. We found that the required information had been obtained.</p> <p>During the inspection in February 2020 we reviewed the staff files for four permanent members of staff and a locum advanced nurse practitioner. We found that although recruitment procedures were in place and the provider operated an onboarding process, not all of the required recruitment checks had been obtained prior to staff starting employment or were on file. We found that staff had started work before evidence of satisfactory conduct in previous employment had been obtained or Disclosure and Barring Service (DBS) checks had been returned. Risk assessments had not been completed to</p>	

mitigate any risks to patients.

A member of staff was asked to provide evidence of their DBS check during inspection. We found information was recorded on the DBS check that the practice had not been made aware of. The provider completed a risk assessment on the day of the inspection to mitigate risks to patients. Following the inspection, the provider confirmed that a significant event had been raised, an internal investigation started and a formal meeting with the member of staff had since taken place.

We saw that the immunisation status for all staff had been obtained.

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: 29/07/2019	Yes
There was a record of equipment calibration. Date of last calibration: 23/03/2019	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: 21/06/2019	Yes
There was a log of fire drills. Date of last drill: 09/07/2019	Yes
There was a record of fire alarm checks. Date of last check: 11/12/19 and weekly checks	Yes
There was a record of fire training for staff. Date of last training: Individual training dates	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 14/01/2020	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our comprehensive inspection in July 2019, we found the provider could not demonstrate the following risk assessments had been completed: fire, control of substances hazardous to health or health and safety check. In addition, the practice could not demonstrate that staff were up to date with fire safety training.</p> <p>During our follow up inspection in October 2019, we saw that a building assurance inspection, which included a fire risk assessment, had been completed by the landlord in July 2019. A new fire evacuation plan was required due to the changes in the building. The landlord had not provided this, so the practice had completed their own, which were displayed in each room. The practice had also completed a risk assessment for the control of substances hazardous to health (COSHH) but did not have the safety data sheets for the products used. We found that staff were up to date with their fire safety training.</p> <p>At the comprehensive inspection in February 2020, we saw that the required safety checks and risk assessments had been completed. There were no outstanding action points from the risk assessments.</p> <p>Staff were up to date with fire safety training. We spoke with a member of staff with additional responsibility as a fire warden. They described the action they would take in the event of a fire. They also told us that the last fire drill was carried out with patients in the building, providing the opportunity to put into practice their fire warden training.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 09/07/2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 09/07/2019	Yes
Explanation of any answers and additional evidence:	

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: 16/11/2018 (External organisation)	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:	
<p>At the time of our comprehensive inspection in July 2019, we found that the provider had not acted to address the issues identified in the infection control audits or could demonstrate that the required actions in the legionella risk assessment had been actioned. In addition, not all staff had completed infection control training.</p> <p>At our follow up inspection in October 2019, we saw evidence that the required actions outlined in the legionella risk assessment had been completed. One of the health care assistants had taken over the lead role for infection prevention and control (IPC). They had completed additional training to support this role. Staff completed the schedule of audits as outlined by the provider and actioned any identified issues. The IPC lead provided feedback to the lead nurse and practice manager on a weekly basis. Training records supported that staff had completed IPC training.</p> <p>At the comprehensive inspection in February 2020, we saw the designated infection prevention and control (IPC) lead continued to monitor IPC within the practice. The IPC lead continued to complete a range of internal IPC audits and report back to the practice manager on a weekly basis. The audits could be improved by including the action taken, completion date and sign off as evidence of action taken.</p> <p>An infection prevention and control audit carried out by the local authority, was due to take place within the near future.</p>	

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
<p>Explanation of any answers and additional evidence:</p> <p>At our comprehensive inspection in July 2019, we found there was insufficient staff to meet the needs of patients or the workload. The provider had not assessed or monitored the impact on safety or on staff. There was limited evidence of risk assessments having been carried out for patients as electronic care plans and risk assessment templates were inconsistently completed. Records indicated that not all staff had completed sepsis awareness training, including the long-term locum GPs. In addition, the practice had not assessed or monitored the impact on safety when there had been changes to the services or staff.</p> <p>Following our inspection In July 2019, a GP Partner and experienced practice manager started working at the practice full time to provide continuity and leadership. The provider had reviewed the existing staffing levels for administrative staff and determined the amount of additional hours that were required.</p> <p>At our follow up inspection in October 2019, we found that non-clinical staffing had increased by one whole time equivalent (WTE) with plans for an additional two WTEs, and the nursing team was increasing by 0.6 WTE. In addition, a clinical pharmacist and allied health care professional had been recruited to support the clinical team. The clinical pharmacist had carried out medicine reviews, high risk medicine monitoring, audits, management of safety alerts and chronic diseases. The allied healthcare professional had a background in frailty and assisted with triage for home visits and also saw patients with musculoskeletal problems.</p> <p>We also saw that the practice manager had introduced rotas for administrative staff to ensure all areas of work were covered and introduced champion roles for staff members for key tasks which enabled them to develop specific expertise in one area. We found that staff had completed training in the identification of the deteriorating or acutely unwell patient potentially suffering from sepsis. Reception</p>	

staff now had guidance to follow to assist them to manage patients with more urgent conditions. We saw that new clinical guidance or evidence-based practice was discussed at clinical meetings, attended by the lead GP and the locum GPs. We sampled the records for patients with a range of long-term conditions or mental health needs. We saw that guidelines had been followed and care plans had been completed.

At the comprehensive inspection in February 2020, we found that practice had continued to increase the staff team to meet the needs of patients and the workload. Additional patient services assistants (PSA) had been appointed, as well as a clinical pharmacist. The practice was also using the services of locum nurse practitioners with prescribing qualifications to increase the number and type of appointments available for patients.

The lead GP continued to provide clinical supervision for the locum GPs, clinical pharmacists and other allied health care professionals. New clinical guidance or evidence-based practice continued to be discussed at clinical meetings and provider level webinars were held once a month to discuss new guidance and updates.

We saw that permanent staff were up to date with their essential training. The on-line training programme alerted staff when essential training had expired and needed to be repeated.

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.	Partial
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: At our comprehensive inspection in July 2019, we found there was insufficient staff to meet the needs of patients or the workload.	

During our follow up inspection in October 2019, we saw that an effective system for the management of referrals had been introduced. We reviewed the tasks and saw that 2 week wait (2WW), urgent and routine referrals were being processed within appropriate timescales. We also found that test results and letters were being actioned promptly.

At the comprehensive inspection in February 2020, we saw the safety netting systems that had been introduced to ensure that referrals, test results and letters were managed appropriately worked effectively. The system had identified that a fast track referral had not been received by the hospital, and staff were able to follow this through and ensure an appointment was sent to the patient. The time between the referral being requested and identifying it had not been received was two working days.

Test results were reviewed by the GP partner, and buddy systems were in place to cover leave or sickness. We saw that results had been reviewed within a timely manner. The practice used a text messaging service where possible to advise patients of their results and if they needed to take any action, or a task was sent to the administrative team to contact the patient.

We found that a backlog of summarising patient notes remained outstanding. Staff told us they logged all notes as they were received, and they were filed in alphabetical order awaiting summarising. They told us that notes from around September 2019 onwards still needed summarising.

Appropriate and safe use of medicines

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

Please note: The Prescribing data relates to the period 01/10/2018 to 30/09/2019. Data collected during this period relates to Forrester Street Medical Practice only.

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) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.39	0.90	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). (01/10/2018 to 30/09/2019) (NHSBSA)	6.5%	5.6%	8.5%	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 (01/04/2019 to 30/09/2019) (NHSBSA)	5.13	5.29	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	0.89	1.92	2.08	Variation (positive)

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

Medicines management	Y/N/Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
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
<p>Explanation of any answers and additional evidence:</p> <p>At our comprehensive inspection in July 2019, we found that the process for monitoring patients' health in relation to the use of medicines including high risk medicines prior to prescribing was not always being followed; nor was there any evidence of monitoring the prescribing of controlled drugs.</p> <p>During our follow up inspection in October 2019, we found that the provider had employed a clinical pharmacist. We saw that the pharmacist had introduced written protocols and systems for medicines management and implemented audits to ensure patients prescribed high risk medicines had their health monitored appropriately prior to prescriptions being issued. An audit to check that shared care agreements were in place with secondary care providers where appropriate had also been undertaken. Quality improvement work relating to medicines had been introduced. The pharmacist had identified an issue with overdue medicine reviews and had concentrated on carrying out reviews for these patients. They were also focussing on polypharmacy for patients on six or more medicines. They had reduced the number of patients in this category from 149 to 58. The pharmacist had started audits on gestational diabetes and anticoagulant and antiplatelets. The first cycle had been completed for both audits, with actions identified which were being progressed.</p> <p>At the comprehensive inspection in February 20202, the practice continued to monitor patients on high risk medicines. Alerts were placed on patient records to flag what medicine they were prescribed, what monitoring was required and who was responsible. We reviewed patients on one particular type of medicine and saw that all patients were up to date with monitoring.</p>	

Medicines management	Y/N/Partial
<p>The practice pharmacist had identified and maintained a register of patients prescribed controlled medicines. The practice was actively identifying those patients prescribed over a specified dose of opioid medicine, inviting them in for a review with the aim of reducing their overall dosage. We reviewed the plan in place for one patient to assist with reducing the overall dosage, as well as a referral to the pain clinic.</p>	
<p>The practice had undertaken quality improvement activity in relation to medicines. Audits had been completed on disease modifying antirheumatic drugs (DMARD), gestational diabetes and anticoagulant and antiplatelets.</p>	
<p>The practice's prescribing of antibiotic items was below the local and national average. Since taking over the practice, the provider had reduced the level of prescribing and had maintained the low level of prescribing over a period of time.</p>	
<p>The practice's prescribing of oral non-steroidal anti-inflammatory drugs was below the local and national averages.</p>	

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 since 29 October 2019:	10
Number of events that required action:	10
<p>Explanation of any answers and additional evidence:</p> <p>At our comprehensive inspection in July 2019, we found that not all significant events were reported or investigated, and any learning that had been identified was not communicated effectively or embedded into practice.</p> <p>During our follow up inspection, we found that staff were following the policies and procedures in place for reporting and responding to significant events. We saw that 27 incidents had been recorded since our previous inspection. We looked at two significant events in detail. We saw that the event had been discussed at the daily huddle meeting, weekly clinical meeting, in addition to a quarterly significant event meeting. Significant events were also discussed at provider level clinical governance group meetings held.</p> <p>At the comprehensive inspection in February 2020, we found that the systems and processes had become further embedded into practice. We saw that significant events were discussed as they arose at the daily huddle, as well as at clinical and practice meetings. Significant events were analysed on a</p>	

quarterly basis, common themes identified, and further actions planned to tackle these. Staff we spoke with were able to share examples and outcomes of significant events raised.

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

Event	Specific action taken
Two patients attended the practice with the same name. Consultation notes were recorded in the incorrect patient's record and prescriptions were issued for the wrong patient.	The error was identified, the patient records were amended, and the correct prescriptions issued. Both patients were contacted and given an apology. Clinicians were reminded to always check the date of birth with patients to ensure they were looking at the correct patient records. The incident was discussed at the daily huddle, clinical meeting and at the significant event review meeting held in January 2020.
Identification of break in the cold chain.	Staff identified that the temperature of the vaccine refrigerator was out of range. Information downloaded from the data logger identified that the fridge had been out of range for 72 hours. Staff followed the correct procedure, contacted the manufacturers and disposed of vaccines as required. Those vaccines which were able to be retained were moved to another fridge and labelled as off label (stored outside of the recommended temperature range but deemed safe to use). A new vaccines fridge was purchased. The incident was discussed at the daily huddle, clinical meeting and at the significant event review meeting held in January 2020.

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
<p>Explanation of any answers and additional evidence:</p> <p>At our comprehensive inspection in July 2019, we found there was a lack of a systemic approach for ensuring patient safety alerts had been actioned.</p> <p>During our follow up inspection in October 2019, we saw that a structured system had been introduced for the receipt, management and recording of safety alerts. The whole system was managed by the clinical pharmacist and the information recorded on a spreadsheet with the actions taken and when completed. Staff were able to describe how they were informed about alerts and we saw that alerts were discussed at the clinical meetings. We found that the alerts had been acted upon and appropriate action taken and recorded.</p> <p>At the comprehensive inspection in February 2020, we found that the systems and processes had become further embedded into practice. We saw that the clinical pharmacist continued to oversee the process and maintain the spreadsheet. We reviewed five recent alerts and saw that these had been acted upon and appropriate action taken and recorded.</p>	

Effective

Rating: Requires Improvement

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19. The QOF data collected between April and September 2018 relates to the previous provider and between October 2018 and March 2019 to Modality Partnership.

Please note: The Prescribing data relates to the period 01/10/2018 to 30/09/2019. Data collected during this period relates to Forrester Street Medical Practice only.

At our previous comprehensive inspection in July 2019 we rated the practice as Inadequate for providing effective services because:

- There was a lack of clinical oversight and structured information sharing.
- There was a lack of quality improvement activity.
- Information was not always shared effectively as it was not always available in a timely manner.
- Some performance data was significantly below local and national averages.

The inadequate areas found during the inspection impacted on all population groups and therefore we have rated population groups as inadequate overall.

At the comprehensive inspection in February 2020, we found that improvements had been made. However, we have rated the practice as requires improvement for providing effective services. This is because we rated three population groups as requires improvement. In particular:

People with long-term conditions

- The quality indicators for diabetes and other long-term conditions were significantly below the local and national averages.

Families, children and young people:

- The practice had not met the minimum 90% target for three of the four childhood immunisation uptake indicators.

Working age people (including those recently retired and students):

- Cervical cancer screening rates were significantly below the national target.
- Screening rates for breast cancer and bowel cancer were below local and national averages.

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
<p>Explanation of any answers and additional evidence:</p> <p>At our comprehensive inspection in July 2019, we found that there was a lack of clinical oversight of the locum GPs and of clinical meetings. The lack of availability of nurse appointments had also impacted on patients receiving long term condition reviews. Information shared with CQC and reviews on the NHS website indicated that some patients felt they were overlooked and ignored by reception staff.</p> <p>At the comprehensive inspection in February 2020, we saw that best practice guidance was discussed at clinical practice meetings held as well as the monthly Clinical Governance Group (CGG) meetings. The new guidance was an embedded document in the minutes of meetings for ease of reference for staff who did not attend the meetings.</p> <p>We saw from the minutes of clinical meetings that information from the CGG meeting was shared with staff. We also saw that clinical updates and new and revised guidance was discussed during the protected learning time as well as in clinical meetings.</p>	

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) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	0.61	0.72	0.74	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 allied health care professional and clinical pharmacist supported the lead GP with these assessments. The reviews included a medicine review and falls risk assessment, at the time of the inspection.
- 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.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- The quality indicators for diabetes and other long-term conditions were significantly below the local and national averages.
- 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. A diabetic nurse from within the Modality group held a diabetic clinic once a month. The practice also worked closely with the community specialist nurses, such as the diabetic specialist nurse.
- 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 home blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	55.6%	77.8%	79.3%	Significant Variation (negative)
Exception rate (number of exceptions).	3.4% (27)	11.6%	12.8%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	54.1%	79.1%	78.1%	Significant Variation (negative)
Exception rate (number of exceptions).	3.4% (27)	5.5%	9.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	66.4%	81.9%	81.3%	Variation (negative)
Exception rate (number of exceptions).	3.9% (31)	8.8%	12.7%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	56.5%	74.7%	75.9%	Significant Variation (negative)
Exception rate (number of exceptions).	1.1% (6)	2.4%	7.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	52.0%	90.2%	89.6%	Significant Variation (negative)
Exception rate (number of exceptions).	2.0% (2)	7.6%	11.2%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	66.1%	82.5%	83.0%	Significant Variation (negative)
Exception rate (number of exceptions).	2.9% (26)	2.2%	4.0%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	74.0%	91.6%	91.1%	Variation (negative)
Exception rate (number of exceptions).	5.7% (3)	4.5%	5.9%	N/A

Any additional evidence or comments
The QOF data collected between April and September 2018 relates to the previous provider and between October 2018 and March 2019 to Modality Partnership. We found that the quality indicators for diabetes and other long-term conditions were significantly below the local and national averages.

However, the practice exception rate reporting was below the national average for all indicators. We asked the provider about what action they were taking to improve these figures.

The practice had identified issues that needed to be addressed to support an improvement in performance. The practice was not assured that coding in relation to long-term conditions was accurate and a review was being undertaken. The system for follow up and recall of patients needed to be strengthened. The practice was also auditing the non-collection of medicines to assess noncompliance with the practice population.

We saw that an action plan had been developed, implemented and discussed at the practice meeting held in January 2020. The practice had identified how many patients within each long-term condition needed to be reviewed before the end of March 2020. The action plan detailed how many patients remained to be seen and which member of clinical staff was responsible for carrying out the review.

The practice had recognised that the availability of nursing team appointments had impacted on performance. The practice had increased the availability of health care assistant appointments through the recruitment of an additional member of staff. A practice nurse skilled in the management of diabetic patients from within the Modality group was reviewing diabetic patients. Patients with more complex needs were referred to the community diabetic nurse specialist.

The practice provided unverified data that was more recent than the data presented in the above tables for the diabetes and long-term condition indicators. The unverified data suggested that the practice had made improvements.

Families, children and young people

Population group rating: Requires Improvement

Findings

- The practice had not met the minimum 90% target for three of the four childhood immunisation uptake indicators. Consequently, the practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all of the four childhood immunisation uptake indicators.
- 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.
- A dedicated baby clinic was held each week, offering 6-8 week baby health checks and postnatal reviews with the GP, and childhood immunisations with the practice nurse.
- 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.
- Midwife lead clinics were held weekly at the practice.
- 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)	98	109	89.9%	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)	130	146	89.0%	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)	134	146	91.8%	Met 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)	131	146	89.7%	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

Please note: The child immunisation data relates to 2018/19. The data collected between April and September 2018 relates to the previous provider and between October 2018 and March 2019 to Modality Partnership. The practice acknowledged there had been an inherited issue with incorrect coding at the time of merger, which resulted in an ineffective recall system. In addition, staff sickness had impacted on the availability of staff to carry out childhood immunisations.

We saw that there was a recall system in place to follow up children who failed to attend for immunisations and that the practice contacted the health visitor when it was appropriate to do so.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice uptake for cervical cancer screening was 61%, which is below the 80% coverage target for the national screening programme. However, there had been an improvement in uptake following the change in provider.
- Breast and bowel cancer screening rates were both below the local and national averages, although there had been an increase in the number of patients attending for breast screening.
- 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.

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). (31/03/2019 to 30/06/2019) (Public Health England)	61.0%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	51.0%	69.3%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	31.8%	51.8%	58.0%	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. (01/04/2018 to 31/03/2019) (PHE)	58.8%	73.5%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	42.9%	45.9%	53.8%	No statistical variation

Any additional evidence or comments

Please note: The cervical cancer screening data relates to period between 31/03/2019 and 30/06/2019 and is for Forrester Street Medical Practice. The breast and bowel cancer screening data and number of new cancer cases collected between April and September 2018 relates to the previous provider and between October 2018 and March 2019 to Modality Partnership.

The practice uptake for cervical cancer screening was 61%, which is below the 80% coverage target for the national screening programme. However, there had been an improvement in uptake following the change in provider. The practice uptake for cervical cancer screening during April 2017 to March 2018 was 56.9%.

The practice was using the services of the community cytology nurse to provide additional appointments. The practice was targeting the younger age women as this group were more reluctant to

attend for screening.

Breast and bowel cancer screening rates were both below the local and national averages, although there had been an increase in the number of patients attending for breast screening. The number of patients attending for breast screening had increased from 40.8% (2017/18) to 51% (2018/19).

The practice provided unverified data that was more recent than the data presented in the above table for breast and bowel cancer screening. The unverified data suggested that the practice had made improvements.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- The practice had identified 49 patients with a learning disability. All patients with a learning disability were offered an annual health check. There were plans to work with the specialist learning disability nurse to support the practice with these checks.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice 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.

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.
- Staff were provided with training on dementia.
- Patients with poor mental health, including dementia, were referred to appropriate services.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	79.0%	91.0%	89.4%	No statistical variation
Exception rate (number of exceptions).	2.5% (3)	7.2%	12.3%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	82.0%	95.0%	90.2%	No statistical variation
Exception rate (number of exceptions).	0.0% (0)	3.8%	10.1%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	67.6%	82.8%	83.6%	Tending towards variation (negative)
Exception rate (number of exceptions).	11.9% (5)	6.7%	6.7%	N/A

Any additional evidence or comments

The practice's performance on quality indicators used to monitor the effectiveness of the care and treatment provided to patients with mental health conditions was below the local and national averages. However, the practice exception reporting rate was lower than the local and national averages in two of the three indicators. We asked the provider about what action they were taking to improve these figures.

The practice had identified issues that needed to be addressed to support an improvement in performance. We saw that an action plan had been developed and implemented and discussed at the practice meeting held in January 2020. The practice had identified how many patients within each long-term condition needed to be seen before the end of March 2020, and which member of clinical staff was responsible for carrying out the review.

The practice offered dedicated clinics for patients with severe mental illness with the GP partner. These patients were offered longer consultations and a health check. However, the practice acknowledged that patients often did not attend for these appointments. The practice sent text reminders and telephoned patients prior to their appointment to encourage attendance.

The practice had identified how many patients living with dementia needed to be reviewed. The allied health professional was responsible for reviewing those patients who were housebound.

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)	459.2	542.6	539.2
Overall QOF score (as a percentage of maximum)	82.1%	97.1%	96.7%
Overall QOF exception reporting (all domains)	6.3%	5.3%	5.9%

	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

<p>At our comprehensive inspection in July 2019, there was little evidence of quality improvement activity within the practice. No clinical audits or quality improvement activity had been completed by the clinicians at the practice. At our follow up inspection in October 2019, we found that the clinical pharmacist had completed the first cycle of a number of audits.</p> <p>At the comprehensive inspection in February 2020, we found there was evidence that quality improvement activity had been undertaken. The practice had recently undertaken four clinical audits, which were linked to best practice guidelines.</p> <p>The first quality improvement activity looked at gestational diabetes and whether patients were offered an annual blood test to check whether their blood glucose levels had returned to normal after birth. The first cycle identified 99 patients, of which 52% had a blood glucose level recorded within the previous 12 months. The second cycle identified 98 patients, of which 60% had a blood glucose level recorded within the previous 12 months. This demonstrated an improvement of 8%. The practice planned to continue to monitor these patients and re-audit in six months time.</p> <p>The second quality improvement activity looked at high risk medicine monitoring and whether patients prescribed a range of high-risk medicines (11 in total) attended for blood monitoring in accordance with the recommended frequency. The first cycle identified that out of the 11 medicines, only patients prescribed two of the medicines were up to date with their blood monitoring. Out of a total of 875 patients, 22% were overdue their blood test, the majority of which were prescribed medicine to treat hypertension. The practice introduced a range of measures to improve the uptake of blood monitoring and safe prescribing. The second cycle identified 896 patients, of which 6% were overdue their blood test. Again, the majority of these patients were prescribed medicine to treat hypertension. However,</p>
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the number of patients overdue their blood test had reduced from 164 to 50 patients.

Any additional evidence or comments

The GP partner reviewed all discharge summaries and took any appropriate action. The practice worked with the rapid response team to support patients in their own homes and prevent admission. The allied healthcare professional, who had a background in frailty, also carried out home visits as required.

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.	N/A
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:

At our comprehensive inspection in July 2019 we found that the practice was unable to demonstrate that all staff were up to date with their essential training. We also found that systems were not in place for clinical supervision of the locum GPs or practice nurses.

At the comprehensive inspection in February 2020, we saw that staff training was up to date and systems were in place to monitoring staff compliance. The lead GP had introduced clinical supervision for all staff employed in advanced clinical practice, and we saw evidence to support that discussion was taking place.

Staff told us they were able to complete their training during the protected learning time. They said they had been offered appraisals and were able to discuss any training or development needs and further develop their skills.

We saw that training needs were also identified from trends with complaints or significant events. For

example, customer service training had been arranged following issues identified as part of these processes.

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 (01/04/2018 to 31/03/2019) (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
<p>Explanation of any answers and additional evidence:</p> <p>At our comprehensive inspection in July 2019 we found that electronic care plans were used inconsistently and potentially impacted on the delivery of care when patients moved between services.</p> <p>At the comprehensive inspection in February 2020, we saw that clinical staff were completing the electronic care plans appropriately. Examples seen included a completed template for a patient with diabetes, and a care plan for a patient with diabetes.</p>	

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
<p>Explanation of any answers and additional evidence:</p> <p>We saw that staff continued to support patients to live healthier lives. Patients were signposted to a variety of local services for support with smoking cessation and obesity. Patients with pre-diabetes had access to a local diabetic prevention programme.</p>	

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	96.7%	96.8%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.6% (10)	0.5%	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
<p>Explanation of any answers and additional evidence:</p> <p>A consent policy was in place, supported by consents forms where appropriate. Verbal consent was recorded in the electronic patient record.</p> <p>During the comprehensive inspection in February 2020, we saw staff had completed training on the Mental Capacity Act. We saw an example where the practice had acted on a request to assess a patient who lacked capacity to make decisions and develop plans for the patient's future care, in the best interest of the patient.</p> <p>Patients who used the video consultation service were required to provide proof of identity, prior to the consultation taking place.</p>	

Caring

Rating: Good

At our previous comprehensive inspection in July 2019, we rated the practice as Requires Improvement for providing caring services because:

- Patients did not always feel that they were listened to or treated with care and concern, involved in decisions about their care.
- Patients were not provided with information regarding alternative provision when staff were unable to offer appointments.
- The number of identified carers was below one percent.
- Confidentiality was difficult to maintain in the main reception area.

Kindness, respect and compassion

Staff treated treat 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
<p>Explanation of any answers and additional evidence:</p> <p>At our comprehensive inspection in July 2019 we found that patients were not always sign posted to alternative provision for accessing a GP appointment when the practice was unable to offer a same day appointment.</p> <p>During the comprehensive inspection in February 2020, we observed staff signposting patients to alternative provision either within the practice, for example, an appointment with the advanced nurse practitioner or a video consultation, or externally at the extended GP access hubs. We saw that patients presenting at the reception desk were dealt with in a timely manner.</p>	

CQC comments cards	
Total comments cards received.	30
Number of CQC comments received which were positive about the service.	26
Number of comments cards received which were mixed about the service.	4
Number of CQC comments received which were negative about the service.	0

Source	Feedback
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CQC Comment Cards	<p>Thirty comment cards were completed by patients. Patients described the staff as friendly, helpful, welcoming and pleasant. Patients commented about being treated with dignity and respect. Patients commented about a number of staff (both clinical and reception staff) and the help and support they had provided. One patient commented positively regarding the new services available to book appointments and another commented that the service had dramatically improved.</p> <p>The four mixed reviews made reference to the challenges around getting appointments, and that some of the GPs were better than others. They felt that some GPs took the time to listen to them whilst they felt rushed with others.</p>
Interviews with patients	We spoke with five patients during the inspection. These patients had mixed views regarding the service provided. Two patients were satisfied with the service and the care they received. Three patients were less satisfied particularly around access, although one commented the service had improved recently.
NHS Website	Nine reviews had been posted on the NHS Website relating to visits since the comprehensive inspection in July 2019. The practice had not responded to all of the reviews. Six of the reviews were negative and referred to the challenges of getting an appointment, telephones not being answered and rude staff. Positive comments were made about the introduction of video consultations and professional staff.

National GP Survey results

Note: The 2019 GP survey was completed during January and March 2019. At this time Forrester Street Medical Centre was registered as part of Modality Partnership. However, it should be noted that patients may be commenting on their experience under the previous providers.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
10092.0	452.0	53.0	11.7%	0.53%

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)	86.5%	87.3%	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)	86.4%	86.2%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and	99.2%	95.0%	95.5%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)				
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)	84.0%	81.6%	82.9%	No statistical variation

Any additional evidence or comments

The national GP survey results indicated that patients were satisfied with the healthcare professionals in relation to being listened to, treated with care and concern as well as with their overall experience of the practice. The practice results in these areas were in line with the local and national averages. Patients satisfaction with the healthcare professionals in relation having confidence and trust in the health care professional was higher than the local and national averages.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	No

Any additional evidence

The practice obtained feedback from patients through the Friends and Family Test and comments and suggestions.

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:	
<ul style="list-style-type: none"> • Patients spoken with told us they were given information leaflets to help them understand their care and treatment. • Information was displayed around the practice in a variety of languages. 	

Source	Feedback
Interviews with patients.	We spoke with five patients during the inspection. These patients had mixed views regarding the service provided. Two patients told us they felt involved in decisions about their care, and the remaining patients told us they sometimes felt involved.

CQC comment cards	<p>Thirty comment cards were completed by patients. Nine patients commented specifically about their concerns and issues being listened to and resolved and both clinical and reception staff. Comments included nothing is ever an issue for them here; reception staff went above and beyond to assist me today; and doctors and nurses always solve my issues.</p> <p>The four mixed reviews indicated that some GPs took the time to listen to them whilst they felt rushed with others.</p>
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National GP Survey results

Note: The 2019 GP survey was completed during January and March 2019. At this time Forrester Street Medical Centre was registered as part of Modality Partnership. However, it should be noted that patients may be commenting on their experience under the previous providers.

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)	92.8%	92.3%	93.4%	No statistical variation

	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:	
We saw that information was displayed around the practice in a variety of languages to meet the needs of the practice population.	

Carers	Narrative
Percentage and number of carers identified.	The practice population was approximately 10,175. The practice had 168 identified carers. This represented 1.65% of the practice population.
How the practice supported carers (including young carers).	The practice had a Carers Champion responsible for maintaining the carers register. The practice had been proactive in identifying and coding carers and had doubled the number of identified carers since the comprehensive inspection in July 2019, when they had only 77 carers on their register. The practice provided carers with a comprehensive information pack regarding local support, entitlements and how to access

	these.
How the practice supported recently bereaved patients.	The practice contacted families following bereavement to offer support and information. The practice took into account the religious and cultural observances of some patients and was able to respond quickly to promote the necessary documentation to enable prompt burial.

Privacy and dignity

The practice tried to respect 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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our comprehensive inspection in July 2019, we found there was a lack of privacy in the waiting rooms. At the comprehensive inspection in February 2020, we found that improvements had been made, but some issues around confidentiality at the main reception remained. We observed that the main waiting area was much calmer and quieter than when we visited in July 2019. Staffing levels had been increased, which allowed dedicated staff to focus on answering the telephones and other staff to support patients presenting at the main reception desk. Electronic self-check-in screens with instructions in a variety of languages had been installed, although not all patients chose to use these. The telephones were now answered away from the main desk, helping to maintain confidentiality. A privacy notice in a variety of languages was in place requesting patients wait behind the line at the reception desk, to afford the person at the desk privacy. We observed that some patients ignored this notice. However, due to the quietness of the waiting room, conversations could still be overheard.</p>	

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

Responsive

Rating: Requires Improvement

At our previous comprehensive inspection in July 2019, we rated the practice as Inadequate for providing responsive services because:

- The practice was unable to meet the needs of the practice population.
- Patients were unable to book either same day or pre-bookable appointments when they needed them. Staff were inconsistent with providing advice about alternative services available to patients.
- Patients found it difficult to get through to the practice on the telephone and often queued to be attended to at the reception desk.
- The premises were not fit for purpose and the planned alterations had not taken place.
- The practice did not document informal comments and complaints and therefore trend analysis and learning could not be derived from these incidents.

The inadequate areas found during the July 2019 inspection impacted all population groups and so we have rated population groups as inadequate overall.

Although it was noted that improvements had been made, the practice continues to be rated as requires improvement in providing a responsive service because:

- Although a new telephone system had been installed, some patients continued to report challenges accessing the practice by telephone.
- Although patients had access to a range of appointments with different clinicians, some patients continued to report that they were unable to get appointments.
- There had been delays to completion of the planned alterations to the premises, which had only recently commenced.

Those areas identified above that require improvement impacted on all population groups and therefore we have rated population groups as requires improvement overall.

Responding to and meeting people's needs

Improvements had been made to how 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.	Partial
The facilities and premises were appropriate for the services being delivered.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Partial
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:	
<p>At our comprehensive inspection in July 2019, we found that the practice was not able to meet the needs of the practice population. There was a high attendance at the emergency department and the walk in centre. In addition, the layout of the building created challenges for both staff and patients and impacted on staffing levels.</p> <p>Following the July 2019 inspection one of the GP partners had taken over the lead role and was based in the practice. An experienced practice manager had also moved to the practice to support the GP partner. Although the practice still relied on long term GP locums, clinical support and guidance was now provided by the GP partner being on site.</p> <p>During the comprehensive inspection in February 2020, we saw that work to alter the layout of the building had started. Alterations were being made to the first floor of the building and once completed, the alterations to the ground floor would be made. The ground floor layout continued to have an impact on staffing levels, as a staff presence was still required in the two separate waiting rooms.</p> <p>The practice told us they had started to work more closely with the consultant at the emergency department as they had a high attendance rate for patients presenting at the department. The practice hoped to identify the reasons why patients attended the department and develop an action to address any issues where appropriate.</p>	

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
Number of GP Appointments available:	
Monday	124
Tuesday	235
Wednesday	124
Thursday	227
Friday	142
Number of Urgent Care Practitioner Appointments available:	
Monday	18
Tuesday	18
Wednesday	12
Thursday	20
Friday	19
Number of Nurse Appointments available:	
Monday	76
Tuesday	77
Wednesday	22
Thursday	70

Friday	116
Number of Health Care Assistant Appointments available:	
Monday	71
Tuesday	29
Wednesday	51
Thursday	56
Friday	54
Number of Clinical Pharmacist Appointments available	
Monday	67
Tuesday	64
Wednesday	38
Thursday	69
Friday	27
<ul style="list-style-type: none"> • GP appointments via video consultation (Push Doctor) were available every day. • The practice employed the services of another provider (WALDOC) for appointments and home visits between 1pm and 2.30pm every weekday and from 1pm to 6.30pm on Wednesdays. • The practice offered patients an extended hours service on Saturdays at a different location (Little London Surgery) between 9am and 2pm. This service offered 20 pre-bookable Advanced Nurse Practitioner appointments and 27 pre-bookable Health Care Assistant appointments. 	

<p>Extended GP Access Service</p> <p>Patients had access to the Extended GP Access Service. Appointments with GPs were available at four hubs within the locality: Darlaston Health Centre, Pinfold Health Centre, Broadway Medical Practice and Portland Medical Practice.</p> <p>Extra GP appointments were available between:</p> <ul style="list-style-type: none"> • 6.30pm – 9pm weekdays (all four hubs) • 10am – 3pm weekends (excluding Darlaston Health Centre & Portland Medical Practice) • 11am – 1.30pm Bank Holidays (all four hubs) <p>Appointments could be booked by calling 01922 501999 during the following times:</p> <ul style="list-style-type: none"> • 8am – 9pm weekdays • 10am – 3pm weekends • 11am – 1.30pm bank holidays <p>The NHS 111 service was also able to book appointments on behalf of patients.</p>

National GP Survey results

Note: The 2019 GP survey was completed during January and March 2019. At this time Forrester Street Medical Centre was registered as part of Modality Partnership. However, it should be noted that patients may be commenting on their experience under the previous providers.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
10092.0	452.0	53.0	11.7%	0.53%

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)	96.5%	93.3%	94.5%	No statistical variation

Older people

Population group rating: Requires Improvement

Findings

The below average patient satisfaction in the 2019 national GP survey as well as the comments made by patients during the inspection had an impact on all population groups in respect of access to the practice and appointments. Consequently, all population groups have been rated as requires improvement.

- 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 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.

People with long-term conditions

Population group rating: Requires Improvement

Findings

The below average patient satisfaction in the 2019 national GP survey as well as the comments made by patients during the inspection had an impact on all population groups in respect of access to the practice and appointments. Consequently, all population groups have been rated as requires improvement.

- The practice provided effective care coordination to enable patients with long-term conditions to

access appropriate services.

- 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 provided in-house electrocardiogram (ECG) which is a test used to check the rhythm and electrical activity of the heart.
- The practice provided an in-house phlebotomy (blood taking) service.

Families, children and young people

Population group rating: Requires Improvement

Findings

The below average patient satisfaction in the 2019 national GP survey as well as the comments made by patients during the inspection had an impact on all population groups in respect of access to the practice and appointments. Consequently, all population groups have been rated as requires improvement.

- 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.
- Most parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice had contact with health visitors during the regular safeguarding meetings.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

The below average patient satisfaction in the 2019 national GP survey as well as the comments made by patients during the inspection had an impact on all population groups in respect of access to the practice and appointments. Consequently, all population groups have been rated as requires improvement.

- Patients were offered an extended hours service on Saturdays at a different location between 9am and 2pm.
- The practice offered daily non-urgent virtual appointments (via a smart phone app) between 9am and 5pm.
- Pre-bookable appointments were available to all patients at additional locations within the area, through the Extended GP Access Service. Appointments were available between 6.30pm and 9pm on weekdays, between 10am and 3pm on Saturday and Sunday, and 11am and 1.30pm on bank holidays.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

The below average patient satisfaction in the 2019 national GP survey as well as the comments made by patients during the inspection had an impact on all population groups in respect of access to the practice and appointments. Consequently, all population groups have been rated as requires improvement.

- The practice held a register of patients living in vulnerable circumstances including homeless people 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.
- A GP from within the group visited the homeless centre on a weekly basis to provide GP services and health checks.
- The practice had appointed an Armed Forces Veterans champion. The practice was actively trying to identify patients through the new patient registration forms and increasing awareness with the practice.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

The below average patient satisfaction in the 2019 national GP survey as well as the comments made by patients during the inspection had an impact on all population groups in respect of access to the practice and appointments. Consequently, all population groups have been rated as requires improvement.

- 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 held dedicated clinics for patients with severe mental health needs, offering a full physical health check and mental health review.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

Improvements had been made although not all people felt they had access care and treatment in a timely way.

National GP Survey results

Note: The 2019 GP survey was completed during January and March 2019. At this time Forrester Street Medical Centre was registered as part of Modality Partnership. However, it should be noted that patients may be commenting on their experience under the previous providers.

	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
<p>Explanation of any answers and additional evidence:</p> <p>During our comprehensive inspection in July 2019, we saw that patients with urgent needs did not always have their care prioritised, as staff did not always advise about alternative provision when the practice was not able to offer an appointment.</p> <p>During the comprehensive inspection In February 2020, we observed staff offering patients appointments with appropriate alternative clinicians within the practice. For example, an appointment with an advanced nurse practitioner, if an GP appointment was not available. We also observed staff signposting patients to alternative provision for access to GP appointments.</p> <p>Since the comprehensive inspection in July 2019, the provider had introduced a new appointment system. The practice now offered a telephone consultation prior to appointments being offered for pre-bookable routine appointments. Patients were advised the GP would call either between certain times in the morning or afternoon, and the GP would offer an appointment later in the day if they thought the patient needed to be see. We saw that the next available bookable telephone consultation was five working days after the inspection.</p>	

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)	47.8%	N/A	68.3%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	56.5%	65.1%	67.4%	No statistical variation
The percentage of respondents to the GP	65.0%	65.2%	64.7%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)				
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)	67.0%	69.8%	73.6%	No statistical variation

Any additional evidence or comments

The national GP survey 2019 results indicated that patient satisfaction with their GP appointment times and type of appointment offered was similar to the local average although below the national average for type of appointment. Patients were less satisfied with getting through to the practice by telephone and the overall experience of making an appointment. These results were below the local and national averages.

Since our comprehensive inspection in July 2019, the provider had reviewed patient access and had implemented a number of changes. We saw during our inspection in October 2019 that telephone system had changed, with additional lines and a queueing system had been introduced. Incoming calls were answered away from the front desk, allowing reception staff to concentrate on supporting patients presenting at reception. A patient self-check in screen had also been introduced. The practice had employed additional clinical staff (a clinical pharmacist and an allied health care professional), resulting in additional appointments being made available for patients. The lead GP was available to support reception staff and clinicians with any queries, or patients who needed to be seen urgently.

The provider had reviewed the GP survey results and an action plan had been developed. This included the further promotion of video consultations, an increase in on-line appointments, telephone consultations and changes to skill mix.

Source	Feedback
Interviews with patients	<p>We spoke with five patients during the inspection. Not all of the patients liked the new appointment system and thought they waited too long for the telephone consultation prior to potentially being offered an appointment. One patient told us that more recently they had been able to get an appointment when they needed on. Some patients continued to tell us that it was difficult to get through to the practice on the telephone at 8am and by the time their call was answered, all of the urgent on the day appointments had been taken.</p> <p>Patients spoken with were not aware that they could access on-line appointments.</p>
Interviews with staff	<p>We spoke with four members of staff during the inspection. They told us that improvements had been made at the practice and they felt more supported and confident in the management team. They told us the changes introduced on the main reception desk had greatly improved working conditions. Staffing levels had improved and staff on reception were now able to assist patients in a timely</p>

	<p>manner and without disruption from the telephones. The telephones were answered away from the reception desk, and a queueing and monitoring system had been introduced, although the provider acknowledged there had initially been challenges with the new system.</p> <p>Staff reported that the level of aggression from patients had greatly reduced as generally they were able to offer patients a range of appointments with different clinicians. However, staff told us that patients were often reluctant to take these appointments as they only wanted to be seen by a GP.</p>
Observation during the inspection	<p>We observed staff answering the telephones. During the time of our observations, the telephone calls were answered within a few minutes. We saw that staff were polite and courteous. Staff explained the appointment system to patients and provided guidance on when the GP would contact them for routine appointments. We observed staff offering patients the opportunity to have a same day video consultation via Push Doctor and some patients chose to take up this option.</p> <p>We observed a member of staff on reception manage several challenging situations in a calm and professional manner. In one instance, the receptionist offered an apology for the patient not being able to contact the practice by telephone. The patient wished to book a GP appointment and an urgent appointment was offered the day after the inspection, which they accepted. In the other instance, a request was made for a same day GP appointment. No appointments were available, and the receptionist offered an appointment with an alternative clinician and signposted the patient to alternative services. The patient was unhappy about this, but the receptionist managed the situation well and the patient agreed to accept an appointment with an alternative clinician.</p>
Interview with care home staff	<p>We spoke with a member of staff from a care home. They told us they thought the service had improved since the inspection in July 2019, although they recognised that it was still work in progress. They said the practice was more responsive to requests for visits, and the allied health care professional attended the home on a regular basis. Although this member of staff dealt with any issues and sought advice and feedback from the GPs as required, care home staff felt that the GPs could be more responsive and visit the home on occasions. They felt that the practice responded to messages promptly and actioned any results in a timely manner. The issue with prescriptions had been rectified and repeat prescriptions were issued as required.</p>
Interview with the Patient Participation Group (PPG)	<p>We met with three members of the PPG and another member contacted us following the inspection. The members had mixed views regarding the practice performance. It was generally agreed that improvements had been made at the practice but a recognition that ongoing work was still required. The members also had mixed views regarding the new appointment system. Some members felt the system worked well, whilst others felt the new system was not suitable for all patients. For example, the elderly or vulnerable patients or those who did not have English as their first language.</p>
NHS Website	<p>Nine reviews had been posted on the NHS Website relating to visits since the comprehensive inspection in July 2019. The practice had not responded to all of the reviews. Six of the reviews were negative and referred to the challenges of getting an appointment, telephones not being answered and rude staff. Positive comments were made about the introduction of video consultations and</p>

	professional staff.
Information received by the CQC prior to the inspection	Information had been shared with the CQC regarding the challenges of getting through to the practice via the telephone and availability of appointments and waiting too long for telephone consultations,

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.	41
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	5
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Partial
There was evidence that complaints were used to drive continuous improvement.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our comprehensive inspection in July 2019, we found the number of complaints recorded was low in comparison to the level of dissatisfaction. In addition, the practice did not record informal comments or complaints and did not have an overall log of all complaints.</p> <p>At our follow up inspection in October 2019, we found that the practice had improved the recording and actioning of complaints. The practice had logged and responded to both written and verbal complaints. Complaints were also discussed at the daily huddle.</p> <p>During the comprehensive inspection in February 2020, we saw that the practice continued log both written and verbal complaints and discuss complaints at the daily huddle. Although all complaints were responded to, we saw that patients did not receive a formal response to informal complaints. Complaints were analysed on a quarterly basis, common themes identified, and further actions planned to tackle these. For example, customer service training was booked for reception staff in February 2020 and the regular review of telephone access to define a performance management plan and benchmarks to monitor.</p> <p>We saw that although information on how to complain was available, patients had to ask staff for a leaflet. There was no information on display in the waiting areas on how to make a complaint.</p>	

Examples of learning from complaints.

Complaint	Specific action taken
Delay in referral to the diabetic clinic	The practice apologised to the patient for the delay with their referral. The practice reviewed the process for managing referrals and dedicated staff were given the responsibility for managing referrals. Referrals have been managed in a timely manner following this incident.
Patient prescribed incorrect medicines and the GP refused to sign an updated prescription.	The patient records were reviewed and it was established that the hospital had not notified the practice of the change in the patient's medicines. An apology and explanation was given to the patient. The practice had implemented a duty doctor system, to enable queries and requests to be actioned in a timely manner.

Well-led

Rating: Good

At our comprehensive previous inspection in July 2019, we rated the practice as Inadequate for providing well-led services and issued a warning notice in relation to good governance. This was because:

- There was a lack of leadership within the practice at all levels.
- Not all staff felt valued, supported or safe in their roles.
- There were gaps in the practice's governance systems and processes and the overall governance arrangements were ineffective.
- The practice had not implemented a clear and effective process for managing risks, issues and performance.
- We saw little evidence of systems and processes for learning and continuous improvement. Not all incidents were reported and investigated and any learning that had been identified was not communicated effectively or embedded.
- The practice did not document informal complaints and therefore trend analysis and learning could not be derived from these incidents.
- There was a lack of evidence of any sustained input regarding leadership at the practice by the provider following the takeover and merger of the three practices.

A follow up inspection on 29 October 2019 we found that the provider had satisfactorily addressed the issues identified in the warning notice.

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.	Yes

Explanation of any answers and additional evidence:

At our comprehensive inspection in July 2019, we saw there was a lack of leadership within the practice at all levels. Although the provider understood and identified actions to address the challenges to quality and sustainability, they had been unsuccessful in addressing these issues since taking over the management of the practice.

Following our comprehensive inspection In July 2019, a GP Partner and experienced practice manager started working at the practice full time to provide continuity and leadership. At our follow up inspection in October 2019, staff told us the change in management had brought about improvements at the practice. We saw that the provider was making progress in tackling the issues that had arisen from the merger of the three practices. Staff told us they now felt that the staff team was more cohesive, and staff had begun to work together as a team.

At the comprehensive inspection in February 2020, staff told us that the improvements noted at our previous inspection in October 2019 had continued. Staff morale had continued to improve through improved communication, increased staffing levels and the visibility and support from the management team. Staff told us that the lead GP provided leadership and support for all levels of staff. All staff were invited to attend regular practice meetings, including daily huddles, and encouraged to contribute their views and suggestions. Minutes of meetings were shared with all staff.

The leaders acknowledged there were still challenges to overcome. The continued challenge was around the recruitment of permanent GPs, in order to reduce the reliance on locum GPs and provide continuity and stability. The leaders were looking to expand the range of health care professionals working at the practice and had employed a number of advanced nurse practitioners and an additional clinical pharmacist.

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:	
<p>The provider had clear values and vision. The vision was to be a leader in delivering resilient community-based services to improve population health across the system. The values of the provider were based around the word 'care' – commitment, accountability, respect and excellence. The values had recently been displayed around the practice.</p> <p>At our comprehensive inspection in July 2019 we found that not all staff were aware of the values and vision or understood the role in achieving them. At the comprehensive inspection in February 2020, we found that staff spoken with were aware of the vision and their role in achieving it.</p>	

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> <p>At our comprehensive inspection in July 2019, we found that the changes in the management and structure of the service and staff shortages had impacted on staff morale and sickness.</p> <p>At our follow up inspection in October 2019 we found that the changes in the management structure at the practice had resulted in an improvement in staff morale. Staff sickness had reduced, and staff were clear about their roles and responsibilities on a daily basis as rotas had been introduced. Existing staffing levels for administrative staff had been reviewed and additional hours provided. Staff acknowledged further hours would be beneficial, although staffing had been improved. The improvements made in the reporting of significant events demonstrated that there were systems to ensure compliance with the requirements of the duty of candour.</p> <p>At the comprehensive inspection in February 2020, we saw that the improvements noted during our previous inspection had been sustained and were becoming embedded. Staff told us they felt supported and were able to raise concerns with the leaders.</p> <p>The provider had a range of initiatives to support the safety and wellbeing of staff. The practice operated a zero-tolerance policy for violence or aggression towards staff. The provider offered staff discounts on a range of products and shops and an employee support service as well as care and long service awards.</p>	

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

Source	Feedback
Staff Interviews	<ul style="list-style-type: none"> Staff reported that morale continued to improve, and they felt they now worked as a team. Workload had reduced and become more manageable due to the increased staffing levels.

	<ul style="list-style-type: none"> The working environment had improved following the changes to the telephone system and reception area.
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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
<p>Explanation of any answers and additional evidence:</p> <p>At our comprehensive inspection in July 2019, we found the provider had governance structures and systems in place, but these were not working effectively.</p> <p>During our follow up inspection in October 2019, we saw evidence to support that the governance structures and systems were being used effectively and showed initial signs there were embedding within the practice. Communication had been improved through the implementation of the daily huddle and clinical meetings. All meetings were minuted and these were shared with staff.</p> <p>At the comprehensive inspection in February 2020, we found the governance structures and systems continued to be used effectively and were becoming embedded in practice. We saw that:</p> <ul style="list-style-type: none"> The governance arrangements in place were working effectively in this practice. Communication within the practice was effective, through the meeting structure, which included the daily huddle, used for sharing information on a daily basis. All meetings were recorded and shared with staff. There was clear oversight of outstanding work, staff performance, management of risks and quality of care. 	

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
<p>Explanation of any answers and additional evidence:</p> <p>At our comprehensive inspection in July 2019, we found that the practice did not have a clear and effective process for managing risks, issues and performance.</p> <p>During our follow up inspection in October 2019 we found that the practice had commenced quality improvement work and completed to first cycle audits. We saw that improvements had been made to recognising, recording and acting upon incidents and complaints and staff were following the policies and procedures. We were told that the locum GPs were being provided with clinical support, although this was not formally recorded.</p> <p>At the comprehensive inspection in February 2020 we found:</p> <ul style="list-style-type: none"> • Staff we spoke with demonstrated a clear understanding of identifying, reporting and escalating risks and were trained in the event of a major incident. Significant events were shared and discussed in meetings held. • The practice had a programme of clinical and internal audit, which demonstrated quality improvements for patients. • Locum GPs and staff working in advanced clinical roles were provided with clinical support and supervision, which was documented. 	

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:	
<p>At our comprehensive inspection in July 2019, the practice was unable to demonstrate that performance was discussed, or any action taken to address shortfalls.</p> <p>During our follow up inspection in October 2019, we found that that communication had improved through the implementation of the daily huddle and regular meeting structure. Clinical staff had access to best practice guidelines, which were also discussed at clinical meetings. We saw that guidelines were being followed appropriately and detailed information recorded in patient records. Clinical information, for example hospital letters and test results, were being reviewed and actioned by the lead GP in a timely manner. The practice had introduced MJOG text messaging. The practice used this system to send appointment reminders and pathology and test results.</p> <p>At the comprehensive inspection in February 2020, we saw the improvements had been sustained. There were systems in place to monitor performance, for example the dashboard. Performance was discussed at the monthly Clinical Governance Group meetings, attended by the practice clinical leaders. We saw that performance was also discussed during clinical supervision, and clinical and practice meetings. We saw that clinical information, for example hospital letters and test results, continued to be reviewed and actioned in a timely manner.</p>	

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:	
<p>Modality Partnership worked with an external organisation (Push Doctor) to provide video consultations for patients. Assurances had been provided that the required checks had been completed for clinicians employed by Push Doctor. Patients who used the service were required to provide identification prior to any consultation taking place. The clinicians were able record information directly into the electronic patient record.</p> <p>Systems were in place to monitor the quality and usage of this service. Modality and Push Doctor held monthly meetings to discuss significant events and complaints. A weekly dashboard of service was shared with Modality. All patients were asked to complete a satisfaction survey after each consultation and this was reviewed as part of a quality improvement process.</p>	

Engagement with patients, the public, staff and external partners

The practice involved 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:	
<p>At our comprehensive inspection in July 2019 we found little evidence to support that the practice acted upon patient views. Verbal complaints were not recorded, analysed or acted upon.</p> <p>At the comprehensive inspection in February 2020, we found that the practice had taken steps to act upon patient views regarding the service. The practice had improved the way in which complaints were managed. We saw that all complaints were recorded, analysed and acted upon. The practice had carried out a quarterly review to identify any themes. The practice continued to work closely with the local clinical commissioning group to develop and improve the service. Staff told us they felt able to make suggestions and they felt they were listened to.</p> <p>Information about the patient participation group (PPG) was on display in the practice. The minutes of the meetings were available, as was the date of the next PPG meeting.</p>	

Feedback from Patient Participation Group.

Feedback
<p>We spoke with three members of patient participation group (PPG). The members expressed differing views on the delivery of the service. They acknowledged that improvements had been made, although not all members agreed with some of the changes had been made. They commented that some patients may be disadvantaged by the introduction of the new appointment system, although others commented that the new system worked well.</p> <p>The members told us that the plan was to meet monthly with the practice, and they were actively trying to attract new members. There were plans to hold the meetings at different times to enable more patients to attend. They told us the meetings were structured but enabled an open dialogue between the members and the practice.</p>

Any additional evidence

<p>We saw that action had taken in response to complaints. This was displayed around the practice in the form of 'You said / We did'.</p> <p>The practice worked closely with the local community. The practice supported charity events, for example, Macmillan coffee mornings and Elf day for the Alzheimer's Society.</p>

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:	
<p>At our comprehensive inspection in July 2019 we found little evidence at the practice to support continuous learning and improvement. We also found that learning from events was not shared effectively.</p> <p>At the comprehensive inspection in February 2020, we found that the provider's commitment to continuous learning and improvement was demonstrated at the practice. The leaders were committed to improving the service, and this was demonstrated through staff training, both essential and developmental; learning from audits, significant events and complaints; ongoing support for staff and structured communication both internal and external to the practice.</p>	

Examples of continuous learning and improvement

- The practice had signed up to participate in the Clinical Commissioning Group (CCG) pilot to implement E-consult. This is an online triage and consultation tool.
- The practice aspired to become a training practice for GPs.
- The practice had undertaken a review of patients with polypharmacy.
- There was opportunity available for clinical staff to learn through Modality webinars.
- Staff were provided with protected learning time as part of their personal learning and development.

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. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- 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.
- 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). This indicator does not have a CCG average and is scored against the national target of 80%.

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>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

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.