

# Care Quality Commission

## Inspection Evidence Table

### Church Lane - Khan (1-537760126)

**Inspection date:** 4<sup>th</sup> and 11<sup>th</sup> May 2021

**Date of data download:** 09 April 2021

## Overall rating: Requires Improvement

At our previous inspection, in August 2019 we rated the service as Requires Improvement overall. This was due to poor governance and strategic oversight regarding the patient record system and gaps in systems associated with safety. At this inspection, we noted improvements in some areas such as national GP patient survey results, safeguarding systems, processes and practices. However, we found ongoing gaps in some governance arrangements, medicine management and effective managing of some clinical indicators. Therefore, the practice continues to be rated as Requires Improvement overall.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

## Safe

## Rating: Requires improvement

The practice continues to be rated as requires improvement for providing safe services. Although at this inspection, we identified some areas of improvements in different aspects of this key question; there were areas where further improvements were required. In particular, management of high-risk medicines were not routinely managed safely. There were some prescribing indicators which were not in line with local and national averages and there were areas of environmental risk which at the time of our inspection, had not been transferred to the practice fire risk assessment.

### Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Y

<b>Safeguarding</b>	<b>Y/N/Partial</b>
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Members of the management team were able to explain actions taken since our previous inspection, to strengthen systems to ensure safeguarding case where family members living in the same household were linked on the practice clinical system. Remote clinical searches carried out by inspectors provided assurance that cases were being linked.</p> <p>Members of the nursing team explained processes for following up children who had not attended secondary care appointments as well as ensuring records were being maintained to evidence actions taken. Initial view of staff safeguarding training records showed that members of the nursing team had not completed safeguarding children level three training updates since the certificate expired in September 2020. Once pointed out by inspectors, the required training was completed during the inspection site visit.</p>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Recruitment records showed that most staff had documented immunisation status recorded; with the exception of non-clinical staff recruited in the last 12 months where there was no record of immunisation status or evidence of a risk assessment to mitigate risks. Following our inspection, the provider explained risk assessments were carried out upon staff induction. The provider also explained where vaccination were unsuitable; risks would be reviewed within a 12 month period.</p>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person.	Y

Date of last inspection/test: May 2021	
There was a record of equipment calibration. Date of last calibration: May 2021	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: 10/09/2020	Y
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Control of Substances Hazardous to Health (COSHH) risk assessments were in place with completed data sheets for all cleaning chemicals used within the practice.</p> <p>During our previous inspection, we noted that the corridor leading to the consulting and treatment rooms were narrow and although staff we spoke with advised that wheelchair users were able to access all required areas of the practice without restriction we noted that such considerations were not included in the practice's fire risk assessment. Members of the management team we spoke with during this inspection explained that a disability access audit had been carried out; however, evidence of this was not provided during our inspection. We also found that completed actions outlined in their fire risk assessment associated with developing a Personal Emergency Evacuation Plan (also known as PEEP) which would focus on developing a specific evacuation plan for patients with a disability and for wheelchair users was not included in the practice fire risk assessment as pointed out during our previous inspection.</p> <p>Following our inspection, the provider submitted evidence demonstrating that findings from the PEEP had been added to the fire risk assessment.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 15/04/2021	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 15/04/2021	Y
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.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 11/1/2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
Explanation of any answers and additional evidence: Members of the nursing team explained that clinical leads assessed what emergency medicines should be available in practice and we saw evidence of a risk assessment for medicines not stocked in the practice. The risk assessment outlined mitigating factors such as the practice being close to two local chemists one of which was open during all surgery hours. The risk assessment also outlined that the stocking of medicines to treat epileptic fits would be reviewed if patients with poorly controlled epilepsy were to register with the practice. However, the risk assessment did not evidence how the provider gained assurance that medicines would be readily available for the practice in the event of a medical emergency. Following our inspection, the provider explained that the practice risk assessment had been amended.	

## 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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Since our August 2019 inspection, the practice continued working and monitoring actions to transfer patient records received from a neighboring practice. The management team provided evidence of an audit carried out in April 2021 which showed between July 2019 and March 2021 out of the 485 patient records which needed to be transferred over to the practice clinical system 20% had received a NHS health check and all had been offered a NHS health check. During our on-site visit members of the management team explained that all patients with the exception of those where no historical paper records were received had an NHS health check. The practice had contacted Primary Care Support England (PCSE) regarding 18% of patients where no historical paper patient records had been received. Members of the management team explained that the practice had signed up for patient record digitisation 2021 (a project aimed to digitize the historic paper patient records held by practices).</p>	

## Appropriate and safe use of medicines

The practice had systems which mainly supported the appropriate and safe use of medicines, including medicines optimization. However, records showed that some patients had not been followed up in line with practice prescribing protocols.

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) (01/01/2020 to 31/12/2020) (NHS Business Service Authority - NHSBSA)	1.09	0.75	0.76	Tending towards variation (negative)
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). (01/01/2020 to 31/12/2020) (NHSBSA)	6.4%	8.6%	9.5%	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 (01/07/2020 to 31/12/2020) (NHSBSA)	5.61	5.19	5.33	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	207.8‰	108.6‰	127.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) (NHSBSA)	1.40	0.68	0.67	Tending towards variation (negative)

Note: ‰ means *per 1,000* and it is **not** a percentage.

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

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Partial
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Remote searches carried out by the inspection team showed medicine management were mainly carried out in line with National recommended prescribing guidance. However, there were areas where some monitoring checks were not included in routine reviews of some high risk medicines. Records viewed did not routinely demonstrate that prescribers checked whether monitoring were up to date prior to authorising repeat prescriptions. We also found that from the clinical records it was not immediately obvious why some patients were prescribed a high risk medicine as patients diagnosis were not being coded in the clinical system (diagnoses codes are used as a tool to group and identify patients).</p> <p>During our on-site visit clinical leads explained that patients who should have been followed up between three to four weeks of prescribing had not been followed up as tasks had not been sent to reception staff by locum GPs in line with practice prescribing protocols. We found that identified patients had not been added to Quality Outcome Framework (QoF) disease registers therefore had not been picked up when carrying out searches.</p>	

Medicines management	Y/N/Partial
<p>Clinical leads demonstrated awareness of prescribing indicators such as antibacterial and Hypnotics which were not in line with local and national averages. Clinical leads demonstrated awareness of antibiotic prescribing guidelines and explained audits were carried out 12 months ago. However, we were not provided with evidence of this at the time of our inspection, and the practice had not revisited these audits. We were told that the practice worked closely with medicine management teams who supported them with monitoring their prescribing practice.</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.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	Five
Number of events that required action:	Five
Explanation of any answers and additional evidence: Significant events recording logs viewed prior to our inspection, outlined the date and brief description of the nature of the incident. However, the log did not provide clarity regarding learning or actions taken to reduce risk of reoccurrence. During our on-site visit we reviewed completed incident reporting forms which showed a more detailed account of the investigation, including learning and actions taken to reduce the risk of the same thing reoccurring. Clinical and non-clinical staff demonstrated awareness of learning from incidents and explained changes made as a result of learning from incidents.	

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

Event	Specific action taken
Blood tests incorrectly labelled	Clinical staff reminded to ensure they check patient details for each sample and ensure all labels correspond with patient details when carrying out the consultation.
Out of date vaccination administered	Staff advised not to solely rely on spreadsheets when checking vaccination expiry dates. Expiry dates placed on vaccination fridges and highlighted to ensure manual checking of expiry dates were carried out prior to administering vaccinations.

Safety alerts	Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: Since our previous inspection, members of the management team had taken action to strengthen systems for receiving, disseminating and ensuring actions from safety alerts were being carried out. Members of the management team explained responsibilities for managing safety alerts had been handed over to the practice nursing team. The management team explained having a designated email address for safety alerts which enables access for clinical staff. Searches following receipt of safety alerts were carried out by the nursing team and shared with GPs for further clinical direction. However;	

records viewed indicated that safety recommendations where not routinely carried out by clinicians once alerted.

## Effective

## Rating: Requires improvement

The practice continues to be rated as requires improvement for providing effective services. This was because, some areas of prescribing did not demonstrate compliance with evidenced based practice; the uptake of national screening as well as childhood immunisation was below target range. Data from the 2019/20 QoF year as well as data over time showed performance continued to remain below local and national averages in areas such as the management of long-term conditions.

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
Explanation of any answers and additional evidence: Evidence gathered during our remote searches indicated that clinicians mainly followed evidence-based practice and guidelines. However, there were areas such as management of high risk medicines and required actions in light of safety recommendations which did not routinely demonstrate compliance with evidence-based practice. For example, there were records which showed that when patients were prescribed medicine where there was a risk of contraindications these had not been altered in line with guidance from the National Institute for Health and Care Excellence (NICE).	

## Older people

## Population group rating: Good

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medicines reviews for older patients.

- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## People with long-term conditions

## Population group rating: Requires improvement

### Findings

- Members of the management and nursing team explained a number of factors which impacted on the practice ability to effectively manage patients with a long-term condition. In particular, staff explained the practice went through a period where they did not have a practice recruited nurse; a GP partner had departed and the impact of COVID-19 resulted in some services being suspended.
- 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.
- There were processes in place to ensure GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Members of the practice nursing team explained that the practice had the equipment to offer patients with suspected hypertension ambulatory blood pressure monitoring. However, due to COVID-19 national procedures to enable safe use of the equipment had not been established; as a result, the practice had suspended the use of ambulatory blood pressure monitoring machines. In replace of this staff explained that the practice issued blood pressure diaries and patients were encouraged to return completed diaries.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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. (01/04/2019 to 31/03/2020) (QOF)	61.6%	74.8%	76.6%	Variation (negative)

PCA* rate (number of PCAs).	1.6% (3)	8.9%	12.3%	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 (01/04/2019 to 31/03/2020) (QOF)	68.6%	89.1%	89.4%	Variation (negative)
PCA rate (number of PCAs).	2.8% (3)	11.6%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	68.3%	80.8%	82.0%	Variation (negative)
PCA rate (number of PCAs).	1.9% (2)	3.7%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	58.5%	65.1%	66.9%	No statistical variation
PCA rate (number of PCAs).	2.4% (6)	13.5%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	57.4%	71.3%	72.4%	Variation (negative)
PCA rate (number of PCAs).	4.7% (28)	6.6%	7.1%	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 (01/04/2019 to 31/03/2020) (QOF)	74.5%	88.5%	91.8%	Variation (negative)
PCA rate (number of PCAs).	5.2% (3)	5.6%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	50.6%	74.4%	75.9%	Significant Variation (negative)
PCA rate (number of PCAs).	2.8% (7)	9.8%	10.4%	N/A

#### Any additional evidence or comments

Members of the management and nurse team demonstrated awareness of the QoF data as well as the reasons for the decline in the effectiveness of the management of patients diagnosed with a long-term

condition. For example, members of the practice nursing team described difficulties faced over the last five years. In particular, taking on additional patients from a neighboring practice which had been closed down; the need to move to a more suitable location; changes with GPs as well as previously being without a regular practice nurse and having to use locums; which impacted on the effectiveness of patients care and management. Following successful recruitment to the practice nursing team two years prior to this inspection, the nursing team identified a huge amount of work required to improve the practice QoF performance. We were told that this had been discussed with the management team and a plan of action had been devised. However, evidence of this as well as discussions regarding performance were not provided during our on-site visit. Members of the management team explained further challenges such as the impact of the COVID-19 pandemic and patients not being able to see GPs face to face further impacted on QoF performance as well as the suspension of some services during the pandemic. However, members of the management team explained where possible during the national pandemic; reviews such as asthma and diabetic reviews were carried out remotely and patients who were able to attend the practice were invited in for a face to face appointment. Staff explained receptionists contacted patients to book them in for their annual review.

Following our on-site visit the practice submitted evidence of a timeline outlining factors which impacted on the practice QoF performance as well as an action plan detailing how the practice intends to improve their QoF performance.

**Findings**

- The practice has not met the minimum 90% for four of five childhood immunisation uptake indicators. The practice has not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for five of five childhood immunisation uptake indicators. (please add additional comment for any childhood immunisations indicators below 90%).
- Clinical staff demonstrated awareness of the childhood immunisation data and explained that the practice continued offering immunisations during the COVID-19 pandemic; therefore, more recent figures were more positive. However, evidence of verified data was not provided during our inspection. Staff explained the practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	36	40	90.0%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	36	41	87.8%	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) (01/04/2019 to 31/03/2020) (NHS England)	36	41	87.8%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	36	41	87.8%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	36	47	76.6%	Below 80% uptake

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

Trend over time showed that uptake of childhood immunisation remained below WHO based national target of 95% (the recommended standard for achieving herd immunity) between 2016 and 2020 for most immunisations; with the exception of the uptake of children aged two who received immunisation for measles, mumps and rubella (one dose of MMR) which was comparable to WHO targets between March 2017 and March 2018. However, data over time showed a gradual decline between March 2018 and March 2020.

Members of the nursing team explained prior to commencing at the practice there was limited structure for managing the call and recall system. As a result, the nursing team introduced offering parents and/or legal guardians an initial appointment to discuss immunisations' which allowed a more informed decision. Staff explained the practice has a large East African population who were reluctant to consent to their children having immunisations. The nursing team explained that once national restrictions were lifted the practice would be exploring the possibility of engaging with community leaders to support with encouraging this population group to present their children for vaccinations. The nursing team were also



exploring splitting up vaccinations so that children can have two vaccinations at one appointment and two a few weeks later.

During our inspection, we were provided with unverified data from the practice clinical system which showed the following:

- 90% of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)
- 93% 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)
- 92% 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)

Following our inspection, the provider informed CQC that since our inspection, they had requested practice data from Child Health Immunisation Service (CHIS) via e-mail and had also spoken to CHIS; however, were awaiting a response. The provider submitted further data following our inspection, covering a time period between January 2021 and March 2021. Whilst data provided indicated an improvement in the uptake of children aged two; the number of children captured in the data were low and the data did not demonstrate whether actions had been carried out to vaccinate children who had not been vaccinated in the previous cohort between April 2019 and March 2020.

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

## Population group rating: Requires improvement

### Findings

- The uptake of cervical screening was below local and national targets. The nursing team demonstrated awareness of this and explained cervical screening appointments had continued during COVID-19 pandemic. However, due to process for cleaning down rooms post appointments this resulted in not being able to offer more appointments.
- 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 medicines 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). (Snapshot date: 30/09/2020) (Public Health England)	64.5%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	57.0%	62.7%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2019 to 31/03/2020) (PHE)	47.8%	N/A	63.8%	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 (01/04/2019 to 31/03/2020) (QoF)	100.0%	94.7%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	36.4%	53.9%	54.2%	No statistical variation

### Any additional evidence or comments

Staff explained prior to COVID-19 patients who did not (DNA) attend their appointment were followed up, and the nursing team discussed concerns regarding screening with patients.

Members of the nursing team explained during the period where the practice were without a regular practice nurse there were high numbers of patients who were exception reported. The nursing team explained work had been carried out to review all historical patients who were exception reported and identified patients were then removed from exception reporting list and contact made inviting them to an appointment. The nursing team explained they initially concentrated on priority areas such as patients who had not had their cervical screening.

**People whose circumstances make them vulnerable**

**Population group rating: Good**

**Findings**

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which 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.
- The practice reviewed young patients at local residential homes.

**People experiencing poor mental health  
(including people with dementia)**

**Population group rating: Requires improvement**

**Findings**

- Staff described systems for monitoring the physical health of people with mental illness, severe mental illness, and personality disorder. However; QoF data showed the number of care plans documented between 2019/20 was below the local and national average.
- During the COVID-19 pandemic some services were suspended; however, staff we spoke with demonstrated awareness protocols for accessing 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 medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- 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 (01/04/2019 to 31/03/2020) (QOF)	24.1%	87.0%	85.4%	Significant Variation (negative)
PCA rate (number of PCAs).	3.3% (1)	12.3%	16.6%	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 (01/04/2019 to 31/03/2020) (QOF)	42.9%	82.4%	81.4%	Variation (negative)
PCA rate (number of PCAs).	0.0% (0)	6.2%	8.0%	N/A

#### Any additional evidence or comments

Clinical leads explained that historically; patients diagnosed with a mental health related condition were not having regular reviews. However; this had changed over the last year with the successful recruitment of additional GP leads. A random sample of records viewed showed that comprehensive care plans for this population group had been carried out. Clinical leads explained that there were ongoing work being carried out which was focused on working through patients diagnosed with severe mental health as well as patients with a learning disability.

#### Monitoring care and treatment

**The practice mainly had a programme of quality improvement activity and reviewed the effectiveness and appropriateness of the care provided**

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	431.31	Not Available	533.9
Overall QOF score (as a percentage of maximum)	77.2%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	6.1%	Not Available	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

During our inspection, clinical leads explained that urinary tract infection (UTI) audits had been carried out; however, no evidence of this was presented. Following our on-site visit the practice provided two audits. The first was a Public Health England (PHE) document on UTI audit published July 2017; however, there was no indication within the document that this was practice specific. The second document provided following our on-site visit was a practice specific audit carried out between January 2021 and May 2021 to ensure that the practice was managing UTIs in line with PHE and the National Institute for Health and Care Excellence (NICE) guidelines. The audit indicated that 100% of patients were prescribed antibiotics in line with PHE guidelines.

The practice provided evidence of an initial audit carried out to ensure safe prescribing of high-risk medicines. The audit identified patients who were prescribed a combined medicine where safety risks had been identified. Actions included making changes to patients medicines in line with NICE guidelines. Audit indicated 93% of patients had their medicine dose reduced or switched to an alternative medicine.

#### **Any additional evidence or comments**

At our previous inspection, we noted significant improvement in the process for coding patients. Previously the practice were able to demonstrate completed action plans and several reviews to show how they had been cleansing and monitoring their patient registers. During this inspection, we saw further progress in relation to cleansing patient registers; and further actions were ongoing to ensure effective monitoring of patients care and treatment.

As part of this inspection, the provider submitted three clinical audits which were viewed by the inspection team. The audits viewed were not dated; therefore, it was unclear whether audits were carried out retrospectively in light of our inspection. The audits demonstrated some element of quality improvement; in particular, the provider had implemented a system for monitoring the prescribing of a specific high-risk medicine. However, clinical records showed some blood monitoring had not been included in patients medication reviews and the audit had not been repeated to demonstrate impact.

Since our previous inspection, the practice continued engaging with stakeholders such as the Clinical Commissioning Group (CCG).

## 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.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: We saw evidence to support that all staff were up to date with their appraisals. There was evidence of an effective induction system in place and we saw that staff were mainly up to date with any essential and mandatory training. During our on-site visit, we were provided with confirmation that safeguarding training updates for identified staff had been completed on the day of our inspection.	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence:	

## Helping patients to live healthier lives

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

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



## 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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence:	

## Caring

## Rating: Good

At our previous inspection in August 2019 we rated the service as Requires Improvement for providing caring services due to low satisfaction rates from patients. At this inspection we found that satisfaction rates had improved in a number of areas, therefore the practice rating has moved to Good for providing caring services.

### Kindness, respect and compassion

**Feedback from patients demonstrated a mixture of positive and less positive comments about the way staff treated people.**

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgmental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence:	

Source	Feedback
NHS Choices	At the time of our inspection, there were a total of 10 patient reviews placed on NHS choices website. Seven were positive and three were less positive about the practice. Patients felt that the practice staff provided them with reassurance and clear advice was offered. Patients also felt that reception staff, nurses as well as GPs all go over and beyond. Other comments included patient's reflection during the COVID-19 pandemic where patients felt that GPs pushed boundaries in terms of support and help. Comments viewed as part of this inspection were placed between January 2020 May 2021.
CQC share your experience	Patient feedback reviewed showed a mixture of positive and less positive experience; in particular, patients felt that over the year's patient care had steadily deteriorate and patient felt staff talked over them.

## National GP Survey results

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 (01/01/2020 to 31/03/2020)	78.9%	87.0%	88.5%	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 (01/01/2020 to 31/03/2020)	71.4%	85.3%	87.0%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)	88.3%	94.7%	95.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020)	68.4%	78.9%	81.8%	No statistical variation

### Any additional evidence or comments

The management team demonstrated awareness of the national GP patient survey results and areas where patient satisfaction was below local and national averages. The practice had an action plan aimed at improving patient satisfaction. This included directing staff to training and carry out a recruitment campaign in order to increase capacity within the clinical team.

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

### Any additional evidence

Previously the practice had carried out their own patient survey. However, due to the national COVID-19 pandemic and lockdown measures the practice had not carried out their own patient survey.

### Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: The practice had a hearing loop, access to interpreters as well as referrals to advocacy services.	

Source	Feedback
Interviews with patients.	Due to COVID-19 related restrictions and reduced footfall within the practice, interviews with patients had not been carried out as part of this inspection.

### National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2020 to 31/03/2020)	84.6%	91.4%	93.0%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	Since our previous inspection, the practice reviewed their carers register and contacted all identified carers to check their caring status. Unverified data provided by the practice demonstrated an increase in the number of carers from 33 to 58 carers on the practices carers register, this represented 2% of their registered patient list.
How the practice supported carers (including young carers).	Staff explained, prior to COVID-19 pandemic the practice took part in a carers week where staff promoted services and signposted carers to community support services. Staff explained that the Patient Participation Group (PPG) were involved in raising carers and patient's awareness of support services.
How the practice supported recently bereaved patients.	The practice sent cards with condolences and supportive bereavement information to recently bereaved patients, they were also signposted to support services such as Cruse Bereavement Care.

## Privacy and dignity

### The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:	

## Responsive

Rating: Good

### Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence: The practice were aware of areas of the premises which required attention and upgrading. The provider were in active discussion with the local Clinical Commissioning Group (CCG) regarding their options. Members of the management team explained that actions such as moving to a purpose built building had been placed on hold due to COVID-19.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8:15am – 6.30pm
Tuesday	8:15am – 6.30pm
Wednesday	8:15am – 6.30pm
Thursday	8:15am – 1pm and 1pm – 6.30pm (access only)
Friday	8:15am – 6.30pm
Appointments available:	
Monday	9:30am – 12.30 and 3pm – 6pm
Tuesday	9:30am – 12.30 and 3pm – 6pm
Wednesday	9:30am – 12.30 and 3pm – 6pm
Thursday	9:30am – 12.30 and 3pm – 6pm (access only)
Friday	9:30am – 12.30 and 3pm – 6pm

## Older people

## Population group rating: Good

### Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients provided by the local pharmacy.

## People with long-term conditions

## Population group rating: Requires improvement

### Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- QoF data over time indicated that historically the practice were not routinely responsive to people with long-term conditions. Data reviewed as part of this inspection, indicated that performance remained below local and national averages.
- Staff explained the practice had developed an action plan aimed at improving care coordination to enable patients with long-term conditions to access appropriate support and 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.

## **Families, children and young people**

**Population group rating: Good**

### **Findings**

- Additional nurse appointments were available until 6pm on a Monday, until 5.30pm on a Tuesday and Wednesday for school age children so that they did not need to miss school. Access to health care assistants were from 8.30am.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Parents with concerns regarding children under the age of 10 could attend a drop-in clinic held at the same time as the twice weekly baby clinic.

## **Working age people (including those recently retired and students)**

**Population group rating: Good**

### **Findings**

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 6.30pm Monday to Friday; except for Thursday where the practice was open until 1pm. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation.
- Patients could also access evening and weekend appointments through the Bordesley Green Access Hub also known as Omnia; of which the practice was part of a Hub for extended access.



**People whose circumstances make them vulnerable**

**Population group rating: Good**

**Findings**

- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

**People experiencing poor mental health  
(including people with dementia)**

**Population group rating: Good**

**Findings**

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

## Access to the service

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

National GP Survey results

	Y/N/Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Patients were able to make appointments in a way which met their needs.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
There were systems in place to support patients who face communication barriers to access treatment.	Y
Patients with urgent needs had their care prioritised.	Y
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff explained on Thursdays when the practice provided an access only service from 1pm; GPs used this time to carry out administrative tasks such as learning disability (LD) and mental health reviews; attend Primary Care Network (PCN) meetings as well as manage their own individual patients. Staff explained, patients were also able to access the practice for repeat prescription requests.</p> <p>We were told that there were on call GPs at the practice on Thursdays for patients who wanted to access a clinician after 11am. Patients were also able to access appointments through the Bordesley Green Access Hub also known as Omnia; appointments were available thought the day, during the day, on evenings from 6.30pm to 8pm and on weekends from 8.30am to 11.30am.</p> <p>Due to COVID-19 the appointment times were extended to enable more access.</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 (01/01/2020 to 31/03/2020)	55.5%	N/A	65.2%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	53.0%	59.4%	65.5%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice	45.7%	59.4%	63.0%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
appointment times (01/01/2020 to 31/03/2020)				
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	58.1%	67.7%	72.7%	No statistical variation

Source	Feedback
CQC share your experience	National GP patient survey results showed an improvement in patient satisfaction with regards to accessing. Information received through CQC share your experience indicated patients were not routinely satisfied with accessing the practice by phone. Members of the management team explained the practice were aware of barriers with getting through to the practice; as a result, the practice had installed additional phone lines since our previous inspection.
NHS Choices	There were mixed views from patients who provided feedback. For example, patients felt that during their appointment they had been made to feel very safe, looked after and always seen on time. Patients appreciated the appointment text reminders to avoid missed appointments. However; patients also reported less positive experiences such as difficulties getting through to the practice by phone and patients were not routinely satisfied with staff attitude.

## Listening and learning from concerns and complaints

**Complaints were listened and responded to; however, records viewed did not demonstrate evidence of learning or actions taken to improve the quality of care.**

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

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Information about how to make a complaint or raise concerns was available in the practice waiting area. There was a complaints policy and form which could be used to capture verbal and hand-written complaints.</li> <li>The practices complaints policy reflected NHS complaints guidelines and patients were also signposted to further support services in the event that they wished to gain additional advice or escalate their concerns further.</li> <li>Complaints logs submitted by the provider ahead of our inspection, showed limited information regarding an analysis such as details of individual complaints, actions taken and identified learning.</li> </ul>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Relates to not being able to get an appointment	Members of the management team explained verbal communication with complainant; however, records to support this had not been provided during our on-site visit.
Complaint submitted to NHSE regarding dissatisfaction with the care a relative had received.	At the time of our inspection, the management team described ongoing communication with NHSE as well as professional medical indemnity services. However, records viewed during our on-site visit did not demonstrate communication with the complainant.

## Well-led

## Rating: Required Improvement

At our previous inspection in August 2019 we rated the service as requires improvement for providing well-led services as we identified that governance across specific areas such as safeguarding, and safety alerts required strengthening. At this inspection, we noted some improvement in these areas; however, we identified that governance arrangements to support effective management of performance and risk required further strengthening. Therefore, the practice continues to be rated as Requires Improvement for providing a well-led service.

### Leadership capacity and capability

**There was compassionate and inclusive leadership at all levels; however, there were areas where leaders understanding of the challenges had not translated into effective leadership.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: Members of the management team and senior partners demonstrated awareness of actions required to address identified challenges such as effective management of patients care. Although the provider had developed an action plan, data over time indicated that the providers action plan had not impacted on the effectiveness of care management.	

### 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.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:  Since our previous inspection; the practice had made further changes regarding succession plans which resulted in successful recruitment of a salaried GP. The management team explained that there were	

plans for the salaried GP to become a GP partner; however, there are ongoing discussions being held with between existing partners.

At the time of our previous inspection, in August 2019 we noted that the practice had made progress with their plans to move to a local more modern purpose built medical clinic in the Spring of 2020. The management team explained that these plans had been placed on hold due to the COVID-19 pandemic. The practice continues to be supported with these plans by their Clinical Commissioning Group (CCG) through successful application of an Estates and Technology Transformation Fund (ETTF). Staff explained once national restrictions have been lifted then discussions regarding the planned move would recommence.

At our previous inspection, there was evidence of positive engagement and collaborative work undertaken with support from stakeholders such as the CCG to address the historical system and coding issues at the practice. At this inspection, audits provided by the management team demonstrated further progress.

## Culture

**The practice had a culture which encouraged high quality sustainable.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	

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

Source	Feedback
Interview with staff	Staff explained that they felt comfortable and confident to raise concerns as well as make suggestions. Non-management staff described management as supportive and approachable. Management described the team as hard working, flexible and explained that during the COVID-19 pandemic staff adapted to rapid changes in guidance positively.

## Governance arrangements

**There were clear responsibilities, roles and systems of accountability to support good governance and management in most areas. However; we identified certain areas where governance arrangements needed strengthening.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	

We noted that the provider had further strengthened the practice governance arrangements in some areas since our previous inspection. However, during this inspection, we identified gaps in arrangements to ensure effective employee immunisation checks and assessments to review staff immunisation needs during and following the recruitment process.

Governance arrangements to ensure clinical staff who were not directly employed by the provider followed up patients in line with practice prescribing protocols had not been established. We also found that the practice had not implemented an effective system to enable early identification of patients who required a follow up appointment to monitor high-risk medicines after being seen by locum GPs. The practice system for managing safety alerts had been reviewed and changes made since our previous inspection. However, we found that processes did not provide assurance that actions to ensure compliance with safety recommendations were routinely carried out.

The management team demonstrated awareness of QoF indicators where performance was below local and national indicators. The practice explained a number of factors; in particular a period where the practice did not have a regular practice nurse as well as changes in the senior clinical team. The practice carried out a successful practice nurse recruitment campaign two years ago as well as recruited salaried GPs. Despite the changes, the practice disease management remained below local and national averages. The management team had developed an action plan to address identified areas; however, a clear timeframe for completion of actions and monitoring of progress had not been established.

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Partial
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
At the time of our inspection, action identified at our previous inspection relating to including the evacuation plan for patients with a disability and for wheelchair users to the practice fire risk assessment had not been carried out. Following our inspection, the provider submitted evidence demonstrating that this action had been carried out.	
Following our inspection, the provider submitted evidence of an action plan to areas of the practice clinical performance. However, the provider did not demonstrate an effective systematic approach to	



improving the quality of patient care, service delivery and respond appropriately without delay to areas such as management of long-term disease.

The practice had carried out a risk assessment which identified a list of emergency medicines which the provider had assessed as not suitable for the practice to stock. The provider recorded mitigating factor such as having access to two local chemists. However, the provider did not provide assurance of an agreement with the chemist or a process for checking whether emergency medicines stocked by the chemist were in date and readily available for the practice in the event of a medical emergency.

## **The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic**

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	

## **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 monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Explanation of any answers and additional evidence:

## Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence:	

## Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
At our previous inspection, we found that the practice had struggled to develop a PPG; however, at this inspection we saw that that provider had developed a remote PPG utilising social media platforms. The COVID-19 pandemic and national lockdown measures which were in place at the time of our inspection as well as changes in priorities, impacted on the progress with development of the PPG. The practice had an action plan which included ensuring that staff involved patients in the decision making process.	

Feedback from Patient Participation Group.

Feedback
At the time of our inspection, the country was in a national lockdown due to the impact of COVID-19 pandemic. As a result, inspectors did not request to speak with the practice PPG as part of this inspection.

## 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.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	

## Examples of continuous learning and improvement

Since our previous inspection, the practice continued engaging with the local Clinical Commissioning Group (CCG). In particular, discussions were ongoing in regard to moving to a more suitable premises. The providers also engaged in conversations with the CCG regarding changes to the practice partnership.

## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.
- **\*PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#) ).
- **%** = per thousand.