

Inspection Evidence Table

Valentine Medical Centre

(1-544352441)

Inspection Date:

Date of data download: 14/11/2023

Overall rating: Good

Context

Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the lowest decile (one of 10). The lower the decile, the more deprived the practice population is relative to others.

According to the latest available data, the ethnic make-up of the practice area is 59.9% White, 18.9% Black, 13.1% Asian, .6% Mixed, and 3.5% other ethnicities.

The age distribution of the practice population closely mirrors the local and national averages. There are equal numbers of male and female patients registered at the practice.

Safe

Rating: Good

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y

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
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> <ul style="list-style-type: none"> The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. The practice held regular multidisciplinary team meetings which incorporated discussions about specific child safeguarding concerns and any concerns relating to vulnerable adults. Staff had access to safeguarding e-learning modules and all staff had completed safeguarding training to the appropriate level for their role. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We saw evidence of the required information in the recruitment records such as a signed contract, employment history, proof of ID and vaccination status. All staff were asked to provide details of their vaccination status which was held in recruitment files. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: March 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: September 2022	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> All staff had completed mandatory health and safety and fire safety training. Risk assessments were carried out by an external company and included electrical, legionella and dangerous substance checks. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: April 2023	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The contract for managing waste and clinical specimens was provided by the Integrated Care Board. (ICB)	

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.	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.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">All staff moved round and spent time working in different roles therefore were multi-skilled and were able to cover for each other when required.We saw there was an effective induction system and ongoing support from management for new and existing staff.Staff had received training in emergency procedures and in identifying patients at risk of deterioration, including suspected sepsis	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients. 	

Appropriate and safe use of medicines

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

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	1.15	0.98	0.91	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2022 to 30/06/2023) (NHSBSA)	7.5%	7.8%	7.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2023 to 30/06/2023) (NHSBSA)	5.29	5.04	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	200.6‰	167.6‰	129.5‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.59	0.76	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	8.6‰	7.4‰	6.8‰	No statistical variation

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
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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective 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 medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
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 and Improvement 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.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
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 UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>As part of our inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor in relation to patients prescribed high risk medicines. These searches were visible to the practice.</p> <ul style="list-style-type: none"> • The provider recorded medicine reviews had been conducted without documenting the details of the review in 4 out of 5 records we looked at. • We reviewed the records of patients prescribed high risk medicines and disease modifying antirheumatic drugs (DMARDs) to ensure they received the required monitoring. The provider was able to demonstrate that it remained safe to prescribe medicines to patients where specific, frequent, monitoring was 	

required. Patients were having blood tests arranged via the hospital and the provider was recording that these indicated it was safe to continue prescribing the medicines.

- We identified 5 patients who had asthma who were managed appropriately and had reviews in the last 12 months but were not all coded as asthma annual review.

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:	9
Number of events that required action:	5 examined
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff told us they knew how to report a significant event and that actions and outcomes from these were discussed with the staff team at regular monthly meetings where themes and trends would be reviewed 	

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

Event	Specific action taken
Mistakenly co-prescribed two types of medicines used for hypertension.	Informed patient and switched one of medicines. Carried out an audit to ensure no other patients being co-prescribed the same medicines. Discussed in clinical education meeting.
Missed anti-coagulation of patient with atrial fibrillation	Arranged an echocardiogram for the patient. Discussed in education meeting. Stressed the importance of annual medicine reviews.

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

Explanation of any answers and additional evidence:

- We spoke with doctors and the practice manager who demonstrated a robust system in place to deal with medical and safety alerts.
- We checked 5 patients from 10 who were on a combination of medications that risks a side effect of hyperkalaemia which is high potassium with risks to the heart. One patient had renal failure and was being appropriately monitored by the practice. 4 patients were being recalled for blood tests at 8 -12 months when the required interval is 6 months. None were at high risk as the last blood tests were normal. Two patients text messages stated they need blood tests because they were on bisoprolol which was not the correct medication that required blood monitoring.
- Patients prescribed high risk medication were all being monitored appropriately.

Effective

Rating: Good

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

Patients' needs were, 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.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.1	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.2	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.3	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
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y

Effective care for the practice population

Findings

- Those patients identified as vulnerable received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice 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.
- 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 assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- We reviewed a number of records of patients with a long term condition and found that all patients were being reviewed in line with national guidance.
- We looked at patients with a potential missed diagnosis of diabetes. We found that all patients were coded as pre-diabetic and being monitored appropriately.
- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
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The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenzae type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	95	106	89.6%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	101	113	89.4%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	100	113	88.5%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	101	113	89.4%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	117	162	72.2%	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
<ul style="list-style-type: none"> The practice was acutely aware of its uptake of childhood immunisations. They worked closely with the local screening team and have signed up to the city wide drive by offering weekend appointments. Open access and opportunistic chances are offered to improve the uptake. Children who were not brought to appointments (DNAs) were followed up with a text and telephone call and then referred to the health visitors and school nurses.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	46%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	61%	N/A	70.3%	N/A

Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	44.6%	54.3%	54.9%	No statistical variation
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (6/30/2023 to 6/30/2023) (UKHSA)	60.3%	N/A	80.0%	Below 70% uptake

Any additional evidence or comments

- The practice was acutely aware of the below target cervical cancer screening rate. Patients were contacted by telephone, text and letter and there were posters throughout the surgery promoting the screening programme.
- We saw evidence that the practice consistently worked to improve the uptake of cervical cancer screening and other cancer screening by phoning, texting and writing to patients who were due to attend.
- Eligible patients were reminded at every opportunity by clinicians in the practice and where they were able, appointments were booked.
- The practice worked with other practices city wide to improve uptake by offering evening and weekend appointments at other locations in the local area.

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.

	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.	Y
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years: <ul style="list-style-type: none"> • A 2 cycle audit of Aspirin Prescribing Without Secondary Prevention Diagnosis was carried out to stop inappropriate Aspirin prescribing in patients without a secondary prevention diagnosis. Where patients had an unrecorded secondary diagnosis this was added to the patient record to improve data recording. • A 2 cycle audit of Gout Management and Allopurinol Monitoring Improved the annual urate monitoring of patients on long term Allopurinol. Improved target urate (below 360mmol/L) levels as per British Society of Rheumatology Guidelines 	
Any additional evidence or comments	
<ul style="list-style-type: none"> • A programme of quality improvement had been established and included a schedule of clinical and non-clinical audits. The practice was running the CQC searches regularly as a way of adding to the programme. 	

- The practice engaged in local quality improvement initiatives and participated in PCN quality improvement programmes.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We found that staff training was up to date and reflected the practice policy and a comprehensive overview of staff training was maintained. • Regular staff appraisals were taking place and an overall practice development plan included details of individual development plans. This allowed the provider to review the needs of the team and training requirements and ensure that resources were allocated to enable training and development to take place. • Staff were given protected time to attend training courses. • Staff were encouraged and supported in their development. For example, one of the receptionists had trained as a phlebotomist, another receptionist was a health care assistant the senior receptionist was training as a care navigator and the practice took part in the city wide nurse and GP mentorship schemes. • The practice applied through the Home Office and is a Tier 2 Sponsor which means that they can employ people who would not normally have the right to work in the UK. This gives them more opportunity to employ people. 	

Coordinating care and treatment

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

	Y/N/Partial
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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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Through joint working with the PCN and local GP Federations, (groups of practices which worked together to offer support to patients), additional support was available for patients with social issues and mental health needs. 	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice worked in a multidisciplinary way with colleagues across health and social care to ensure coordinated care was in place for vulnerable patients and to support patients and their families at the end of life. The practice nurse held NHS health check clinics and supported patients who wanted to stop smoking, lose weight, become more active and make improved lifestyle changes. Patients could be referred to other services for support if they wished. The practice told us that they were heavily involved at setting up a lung cancer screening pilot in the city which is now a national screening service. 	

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. 1	Y
<p>Explanation of any answers and additional evidence, including from clinical searches:</p> <ul style="list-style-type: none"> • Our clinical review of notes where a DNACPR decision had been recorded, this identified where possible, patient views had been sought and respected and we saw that information had been shared with relevant agencies. 	

Responsive

Rating: Requires Improvement

We recognise the pressure that practices are currently working under and the efforts staff are making to maintain levels of access for their patients. At the same time, our strategy makes a commitment to deliver regulation driven by people's needs and experiences of care. Although we saw the practice was attempting to improve access, this was not yet reflected in the GP patient survey data or other sources of patient feedback. Therefore, the rating is requires improvement, as ratings depend on evidence of impact and must reflect the lived experience that people were reporting at the time of inspection.

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.	Y
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

Practice Opening Times	
Day	Time
Opening times:	
Monday	8:45am – 6pm
Tuesday	8:45am – 6pm
Wednesday	8:45am – 6pm
Thursday	8:45am – 6pm
Friday	8:45am – 6pm

Telephones are answered Monday to Friday from	8am – 6:30pm
Appointments available:	Throughout the day. Extended hours, until 8pm and at weekends are offered at various locations in the Primary Care Network area.

Further information about how the practice is responding to the needs of their population

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred. Although this has never happened at the practice, the GP would if required
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional nurse appointments were available in planned evening clinics for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a Primary Care Network. Appointments were available Saturday and Sunday.
- 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. Patients could use the practice address if required.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- Weekend and evening clinics were held at various locations in the PCN area and throughout the city offering cervical cancer screening and childhood immunisations.

Access to the service

People were not always able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Partial
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y

There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The patient voice about difficulties in getting through to the practice by phone and in obtaining an appointment was evident in the national patient survey results. The practice received lower than local and national average scores for patient satisfaction in the national patient survey for questions about patient experience of making an appointment and satisfaction with appointment times. Telephone and on-line appointments were offered to patients who required them. There was an extended hours service offered where patients could see a GP or nurse at another location in the evenings, weekends and bank holidays. 	

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2023 to 30/04/2023)	29.8%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	37.4%	55.2%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	37.2%	56.2%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	73.2%	71.0%	72.0%	No statistical variation

Any additional evidence or comments

<ul style="list-style-type: none"> The practice is acutely aware that results of the National GP survey are below local and national standards and has signed up to the General Practice Improvement Programme for access. This is through the Primary Care Network (PCN) and means working together with other practices in the PCN to improve access in the area. The practice is planning to install a new telephone system with virtual queuing which means if patients wish to they can press for a ring back when they have reached the front of the phone queue.

Source	Feedback
NHS.uk website (formerly NHS Choices)	2 reviews were left in 2023. 1. "The reception staff go out of their way to help. Recently I have seen two doctors and they have both been so understanding and caring. They review their treatment. They listen. A very good service." 2. "Phoned Valentine Medical centre 9:10 am monday morning and was told no appointments available and I should phone the following day at 8:45 and never asked what the problem was and could not make appointment for following day. Reception staff not very helpful"
Patient we spoke to	Receptionists are lovely and doctors are fantastic. The GPs always listen.

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.	7
Number of complaints we examined.	7
Number of complaints we examined that were satisfactorily handled in a timely way.	7
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Example(s) of learning from complaints.

Complaint	Specific action taken
3 complaints were about being unable to get an appointment,	3 received by email. 2 were contacted by the practice, apologies given and appointments made The practice was unable to trace 1 patient where the complaint was received by email.
There was a missing item from a prescription requested.	The practice was unable to say why the prescription had a missing item as it appeared to have not been requested. An apology was given and the item issued.

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
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: <ul style="list-style-type: none">• Leaders were actively engaged in quality and operational sustainability, including working collaboratively with other agencies to develop services across the local community.• All staff who completed a questionnaire told us that they felt supported by the GPs, management and their peers. They said that the partners and management were visible and approachable.• The practice had successfully recruited to a range of positions including a newly qualified GP and nurse.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	
Staff knew and understood the vision, values and strategy and their role in achieving them.	
Progress against delivery of the strategy was monitored.	
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The GPs met every day at 12:30 to discuss patients and offer peer support.• The GPs and management held an annual strategic planning day, off site and on a weekend to discuss and review the business plan and staff profile. This was then shared with all other staff and the patient group who were asked for their views.	

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.	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 had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y

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

Source	Feedback
Staff questionnaires and staff we spoke with.	<ul style="list-style-type: none"> • We work well together as a team. • Management and doctors are all approachable • It is a friendly place to work • Everyone is supportive of each other

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • A regular meeting structure was in place for all team members. This enabled the review of issues such as infection prevention and control, significant events and complaints. • There was a data sharing agreement in place with local teams regarding vulnerable patients 	

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.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
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

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
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The clinical searches undertaken as part of the inspection found effective systems and processes for monitoring care and treatment. The practice had a range of meetings scheduled to monitor performance and keep staff up to date. These included management and administrative briefings, clinical, nurse, staff meetings and management/business meetings. There was an audit schedule in place and results were discussed during clinical meetings. 	

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
Staff are supported to work remotely where applicable.	Y

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: <ul style="list-style-type: none"> • The practice had a newly re-grouped patient group which was to be included in the planning of services. • Staff were encouraged to give their views in meetings when planning services. • The practice worked alongside the Primary Care Network (PCN) and Integrated Care Board (ICB) to work together and identify ways in which they could meet the needs of patients. 	

Feedback from Patient Participation Group.

Feedback
The GPS and management listen to the PPG The PPG feel valued as part of the group Members of the group want to have some education days to try to increase uptake in screening.

Continuous improvement and innovation

There were 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: <ul style="list-style-type: none"> • The practice was able to evidence a number of audits undertaken which represented a cross section of the patient population. Audits were used to drive improvements and review the care offered to patients. Audits were reviewed against targets and best practice and achievements noted. • Staff were supported in their development and a training plan in place. 	

Examples of continuous learning and improvement

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. 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 persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for those aged 25 to 49, and within 5.5 years for those 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.
- **UKHSA:** UK Health and Security Agency.
- **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.
- ‰ = per thousand.