

# Care Quality Commission

## Inspection Evidence Table

### Your Health Partnership (YHP) (RXK36)

Inspection date: **11 to 28 October 2022**

Date of data download: 10 October 2022

## Overall rating: Requires improvement

We found that while the practice had implemented systems and processes to ensure the safe and effective delivery of services, the practice could not demonstrate these were all fully embedded or effective. The practice is therefore rated **requires improvement**.

## Safe

## Rating: Requires Improvement

We found that systems and processes were not always followed or fully effective. The practice is therefore rated **requires improvement** for providing **safe** services.

### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence:	
The provider had produced adult and children safeguarding policies. We found the practice had also produced more local policies that provided staff with information that was specific to their roles. Staff were able to tell us who safeguarding leads were and how they would access relevant policies.	

Safeguarding	Y/N/Partial
<p>We found that policies were in date, had been reviewed and were version controlled, so that any changes could be more easily identified.</p>	
<p>We saw evidence of safeguarding meetings, where the practice discussed vulnerable patients. From evidence we viewed we saw that information relating to safeguarding was discussed in Quality and Safety meetings and information was shared with all staff through clinical update newsletters each month.</p>	
<p>Unfortunately, our GP specialist advisor was not provided with the full access they needed and were not able to fully view all safeguarding information contained within records. However, the practice staff were able to demonstrate how information was recorded and which safeguarding codes were used to help remind staff that there were safeguarding concerns.</p>	
<p>Staff told us that compliance with required training, which included safeguarding training was monitored by the provider, and this information was shared monthly with the senior management team. From evidence we viewed we saw that in October 2022 83% of relevant staff had completed level 3 safeguarding training for children and 73% had completed level 3 safeguarding training for adults.</p>	
<p>The senior management team were aware there were gaps in compliance in training and explained this was due to a combination of new staff joining the practice and existing staff were not able to attend face to face training during the pandemic. They told us that all 8 clinical staff that were overdue with safeguarding training had all been booked onto the training.</p>	
<p>We found that while most staff had access to safeguarding information, if relevant for their role, not all staff were provided with the correct access that would allow them to view safeguarding information. This was raised with the senior management team who agreed to review and grant these staff with the correct access rights.</p>	

Recruitment systems	Y/N/Partial
<p>Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).</p>	Yes
<p>Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.</p>	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Recruitment checks and staff vaccination was managed centrally by the provider's human resources HR and occupational health teams.</p> <p>We found that the practice management team had access to and oversight of relevant recruitment information, and staff told us they were informed of any occupational health issues through the provider's electronic recruitment system. From staff recruitment files we viewed, we saw that information relating to occupation health issues was visible.</p> <p>We reviewed 7 staff vaccination records and found that staff mostly had all vaccinations relevant to their role. However, there were gaps in both clinical and non-clinical staff records that we viewed.</p>	

We were told that the provider's process was where immunisations were not up to date an employee may be cleared to work with adjustment and the manager should then undertake a risk assessment to support their staff in the workplace.

However, the senior management team did not provide evidence of risk assessments and told us if there were any gaps in immunisation status the provider's occupational health team would liaise directly with the staff member to arrange for this to be done.

Safety systems and records	Y/N/Partial
<p>Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: November 2021 (actions completed)</p>	<p>Partial</p>
<p>10.10.22 Safe and legal check at branch site, however no overall health and safety risk assessment</p>	
<p>There was a fire procedure.</p>	<p>Yes</p>
<p>Date of fire risk assessment: January 2019 at main practice. Actions from fire risk assessment were identified and were completed</p>	<p>Partial</p>
<p>Explanation of any answers and additional evidence:</p> <p>The senior management team had a system in place to monitor risks related to the premises and were clear on what actions they were responsible for and which action the provider's estates team were responsible for.</p> <p>They had processes in place to discuss health and safety concerns and for escalating concerns to the provider.</p> <p>The senior management team told us they had been advised by the provider to continue to use previous health and safety and fire risk assessments if there had been no changes, and to monitor risk using the safe and legal checks.</p> <p>Staff told us they carried out daily and weekly safe and legal checks on the premises and if any concerns were identified during the checks these were raised with their line manager and then reported to the provider's Estates team.</p> <p>We saw evidence of safe and legal checks being carried out for the main practice and branch practice. We saw that these checks included checks related to health and safety, security, infection control and some aspects of fire risk management</p> <p>During our site visit to the main practice Regis Medical Centre, we found that lights were flickering on one of the corridors. Staff told us they were not aware of this and could not evidence it had been reported.</p> <p>The branch practice was a new building and had not had a health and safety or fire risk assessment. During our inspection we identified that there were no evacuation chairs on upper floors. We also did not see any fire signs around the building, to help people in the event of a fire emergency. We did not see</p>	

any reference to evacuation chairs or lack of fire signs on the safe and legal checks that were carried out for this site. We viewed the Fire Safety manual for the branch site, it made reference to refuge areas, however it did not go into detail about evacuating less mobile people out of the building. The senior management team told us they had been asked to produce a plan for evacuating people with additional needs out of the building, they did not provide any evidence of this.

We found for the main practice, not all actions following the fire risk assessment in January 2019 had been completed, this included the electrical wiring. The senior management team told us they were aware this was still outstanding and had raised this with the provider's Estates team.

The main practice and branch practice had not had a fire drill in the past 12 months. The senior management team told us that all sites had recently appointed Fire Marshalls, they had all completed face-to-face training, and fire drills would be completed at all sites by the end of December 2022 and would be repeated 6 monthly thereafter.

For both sites we saw that fire extinguishers had all been checked and serviced.

We saw that equipment on both sites had been calibrated and the senior management team had processes in place to monitor this.

From visual checks during the inspection and from IPC audit information we viewed we saw that electrical equipment had been PAT (portable appliance test) tested and staff monitored this.

The main practice and branch practice had risk assessments for Legionella and processes in place to reduce and manage any related risks (Legionella is a bacterium that can live in water systems under certain conditions).

During the site visit we found the control of substances hazardous to health (COSHH) risk assessment for both the main practice and branch had expired in March 2022.

## Infection prevention and control

### Some systems to manage infection, prevention and control required improvement.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:Ongoing	Yes
The practice had acted on any issues identified in infection prevention and control audits.	No
The arrangements for managing waste and clinical specimens kept people safe.	Partial
Explanation of any answers and additional evidence:	
From evidence we viewed we saw that 93% of staff had completed relevant IPC training.	

The practice had an audit schedule in place to monitor and manage risk related to IPC. We saw that different aspects of IPC were monitored daily weekly or monthly.

We viewed a sample of these audits, these included: spot checks done on clinical rooms, hand hygiene audits, medicines audits and fridge audits.

During our site visit to the main practice, we did not identify any IPC concerns.

At the branch site Lyndon Primary care centre, we found that sharps bins were not signed or dated in line with the practice's policy.

Audits done earlier in the year in April 2022 had looked at whether sharps bins were labelled correctly and had not identified any concerns.

The practice had arrangements for keeping clinical waste secure before it was collected. However, we found there was confusion about whether clinical waste bags should be labelled or not. The senior management told us the clinical waste company did not require them to label bags however the practice policy requested that clinical bags were labelled.

IPC audits also monitored if staff mandatory training was 100%. The audit from October 2022 showed that training achievement was greater than 95%, but not 100%. There was a comment on the audit that this had been added to the action plan. The action plan was not shared with us.

The minor surgery audit completed in July 2022, asked if the room had twice daily cleaning scheduled as this was considered best practice. The staff completing the audit had commented that the schedule indicated once daily, however there were no further comments to indicate that this had been escalated or that other mitigation was in place.

Following the inspection, the provider told us the room was only used for 1 session each day. The room was cleaned before the session began and would then be cleaned the following morning before the next session.

IPC action plans were requested but not shared with us.

## Risks to patients

### There were adequate systems to assess, monitor and manage most risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
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.	Partial
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes

Explanation of any answers and additional evidence:

Staff could tell us what action to take if a patient was deteriorating however not all non-clinical (patient facing) staff had received sepsis training and told us they had not been provided with guidance they could easily refer to should they need it to help identify patients who may possibly have sepsis.

From evidence we viewed we saw that 75% of staff had completed basic life support training. Following the inspection, the provider told us during the COVID19 pandemic, staff were not able to access this training, however all staff will have completed it by the end of March 2023.

The practice had processes in place to monitor that checks on emergency equipment had been carried out and that relevant equipment was on site.

### Information to deliver safe care and treatment

#### Staff did not always have 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. <sup>1</sup>	Partial
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial

Explanation of any answers and additional evidence:

Our review of patient records identified that care records were not always managed in line with current guidance. For example, management plans were not adequately documented or coding was incorrect.

The practice had processes to request and monitor urgent referrals to other services, however we found processes were not robust and were not always followed. For example, the senior management team had developed a template for clinical staff to use. The template acted as a prompt to remind clinicians about completing certain tasks to ensure the referral was properly processed. During the inspection, our record review found an urgent referral that had not been sent to the correct team for processing and had then not been followed up by the clinician.

The practice had processes to manage test results and correspondence from external services. However, we found that processes were not always followed and the practice could not evidence that processes were being effectively monitored.

We found blood test results dating back to August 2022 that had either not been viewed or actioned and letters dating back to June 2021 that had not been actioned or filed.

Staff used tasks to remind themselves or ask others to complete an action. We found tasks dating back to September 2020 were still open. The practice management team told us they had a system in place to monitor tasks and that the non-clinical team monitored for tasks older than 12 months and would let the relevant staff member know. We found evidence that this process was not being followed.

## Appropriate and safe use of medicines

### The practice's systems for ensuring the appropriate and safe use of medicines, including medicines optimisation required improvement.

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 average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.85	0.83	0.82	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). (01/07/2021 to 30/06/2022) (NHSBSA)	5.8%	6.1%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	5.18	5.20	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	144.9‰	139.0‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.57	0.66	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	8.7‰	8.7‰	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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. <sup>1</sup>	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Partial
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. <sup>2</sup>	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
Explanation of any answers and additional evidence, including from clinical searches.	
The management of prescribing competence of non-medical prescribers was not consistent. The senior management team told us the provider was in the process of reviewing the trust's non-medical policy which would include the governance arrangements required for admission and ongoing monitoring required to remain on the Trust's non-medical prescriber register and the senior management team were waiting for further guidance from the provider.	



## Medicines management

Y/N/Partial

All non-medical prescribers we spoke with during the inspection told us they had access to support from GPs to discuss prescribing concerns, however not all had received any feedback on their prescribing decisions or were aware that an audit had taken place to monitor their prescribing decisions.

From evidence we viewed and from what staff told us, staff had opportunities to discuss prescribing, however, there was no direct monitoring of prescribing decisions for all non-medical prescribers.

We saw evidence of the schedule used for carrying out safety searches, to monitor that patients prescribed particular medicines were being monitored in line with guidelines. From evidence we viewed and from our record reviews, we found the practice could not demonstrate that their schedule included all relevant high risk medicines that required regular monitoring.

Review of five clinical records, identified by the clinical search, for patients taking a medicine to treat inflammatory conditions such as rheumatoid arthritis or Chron's disease, showed that in all 5 records there was no evidence that the prescriber had checked that relevant monitoring was up to date before issuing the prescription. In one record we found a letter from secondary care advising the patient attends for a blood test had been filed without actioning.

Where patients were having blood tests arranged at the hospital and there was an agreement in place for this, the practice could not demonstrate that staff were routinely recording that these blood tests indicated it was safe to continue prescribing the medicines.

The senior management team told us, following the clinical record reviews, that they acknowledged that while they had processes in place to monitor this group of patients, this could not be fully demonstrated as results had not always been downloaded into the patients records.

We reviewed 5 records, identified by the clinical search for patients taking a medicine to treat or prevent blood clots. Our review showed that in 3 records, there was no evidence the prescriber had checked monitoring was up to date before issuing a prescription. For one patient the medicine dose was worked out using a weight measured in 2019.

Our searches revealed that a particular monitoring, which should be calculated to monitor that patients are receiving the correct dose had been calculated for 73% of patients 2 weeks before the inspection.

The practice management team acknowledged they had only recently implemented this monitoring as evidenced by our searches and record reviews.

Our record reviews also indicated that medicine reviews were not always comprehensive. The reviewer did not always review all repeat prescriptions during the review or document that required monitoring was up to date. We also found an example where a record had been incorrectly coded as having a medicine review, when only a care home review had been carried out.

Our evidence indicated the practice did not have effective processes in place for monitoring patients' health in relation to the use of all medicines (including high risk medicines) with appropriate monitoring and clinical review prior to prescribing.

At the main practice Regis Medical Centre we checked which emergency medicines the practice kept on site and found the practice kept all medicines that the provider had included on their list of medicines that

Medicines management	Y/N/Partial
<p>would be kept on site, as listed in the red emergency bag rollout guidelines. The practice did not keep other suggested emergency medicines that may be required in an emergency. We asked if a risk assessment had been completed to help decide which medicines were kept on site and what staff would do to help support patients in an emergency. However, this was not provided.</p>	
<p>We saw that the practice had processes in place to monitor stock of medicines. The practice told us they had implemented a process to action and manage letters from external organisations. Non-clinical staff had received training on how to code these letters, and what to do if they needed actioning. The senior management team described the process and we saw evidence of audits for monitoring this system, to demonstrate it was working as intended. The results of the audits were discussed each month during Quality and Safety meetings.</p>	
<p>The practice's audit in August 2022, which had audited 413 letters coded since January 2022 showed that 95% of these letters had been coded correctly, 3% had been coded at an acceptable level and 2% (8) of these letters had been coded incorrectly.</p>	
<p>We saw from the senior management team meeting minutes in September 2022 the team had discussed that 1.9% of letters had been coded incorrectly, and although no harm had occurred, going forwards the person completing the audit would be making suggestions on how coding could be improved if errors were found.</p>	
<p>During our record reviews, from the sample of records we viewed we found examples where letters had been filed without actions being completed.</p>	

## Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	22
Number of events that required action:	21
<p>Explanation of any answers and additional evidence:</p> <p>Details of incidents for this practice and other practices within the primary care network (PCN) were discussed with practice staff. Information was discussed in Quality and Safety meetings. Staff told us they would learn about incidents if it was relevant for their role.</p> <p>During the inspection, not all staff could recall incidents or subsequent learning. However told us learning from incidents was shared in monthly newsletters.</p>	

At the time of the inspection, not all staff had access to the provider's incident reporting system, staff told us they would inform the lead for incidents, who would then log the information on the provider's IT system.

The senior management team told us this had already been raised with the provider.

From evidence we viewed we saw that learning from incidents was shared with all staff.

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

Event	Specific action taken
A local pharmacy was changing where patients could collect their prescriptions from, without the patients' consent	Staff had reported this to senior management team as complaints came into the practice. The senior management team had notified NHS England. Staff were aware they needed to continue to let the senior management team know about any further complaints in regard to this.
Data breach	The practice investigated the incident and contacted the patients involved. Staff were reminded to be more vigilant and check patient details when sending correspondence out.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. <sup>1</sup>	Partial
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice could demonstrate they had systems in place to receive and discuss safety alerts and could evidence how this information was shared with all staff.</p> <p>The practice shared evidence to show how alerts were responded to and we saw evidence of clinical audits that monitored that medicines were being prescribed in line with guidelines. However, the practice could not demonstrate that all relevant safety alerts had been responded to or that searches included all medicines that required regular monitoring</p> <p>We found evidence of medication reviews carried out by clinicians where the risks, following a safety alert had not been documented in the patients records to indicate that risks had been identified and the risk discussed with the patient or alternative treatments considered.</p> <p>We reviewed 5 records identified by a clinical search for patients taking medicines for low mood In 4 of the 5 records we viewed we found the age related risks had not been discussed and for one patient a GP had recently increased the medicine dose without a discussion about risks.</p> <p>The practice did not have a system in place where staff had to acknowledge they had read the safety alert and taken any relevant action. Staff we spoke with during the inspection, confirmed they did not have to report to anyone on action taken.</p>	

## Effective

## Rating: Requires improvement

We found that patients with long term conditions were not always reviewed in line with guidelines, or that medication reviews were not always comprehensive. The practice had not achieved the WHO immunisation target for children's vaccinations and cervical cancer screening remained below target.

The practice is therefore rated **requires improvement** for providing **effective** services.

*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 not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. <sup>1</sup>	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated. <sup>3</sup>	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Partial
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice prioritised care for their most clinically vulnerable patients.	Yes
Explanation of any answers and additional evidence: Our record reviews and clinical searches indicated that patient's treatment was not always followed up in line with guidelines and that patients on high risk medicines did not always receive the correct monitoring before a prescription was issued.  For example, we reviewed 5 records for patients prescribed a medicine used to treat anxiety and/or nerve pain. Our review showed all 5 patients had not received a medication review in the last 12 months in line with guidelines.	

From data we viewed from September 2022, we saw the practice was below their own target of monitoring 95% of all patients prescribed disease modifying anti-rheumatic drugs (DMARDs).

We found records that had been coded incorrectly, this gave misleading information that reviews had been carried out when they had not.

Medication reviews, we viewed, were not always comprehensive.

We found an example where an urgent 2 week wait referral had not been sent.

## Effective care for the practice population

### Findings

- Staff told us, during the pandemic, they continued to review patients. They worked from risk lists, to focus on those with urgent needs.
- 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.
- Frailty assessments, were offered to patients over 75 years of age.
- All new patients were offered a health check within the new patient registration process however at the time of the inspection the practice were not routinely inviting patients in for health checks. The practice told us, all patients with long term conditions or those in vulnerable groups such as care home patients and carers were offered health checks and where a health check was requested, this would be arranged.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients.
- At the time of the inspection, of those patients with a learning disability, 24% had received an annual health check review and 41% of patients with a learning disability had been invited in for a health check. The senior management team were aware they were behind schedule with these reviews and told us of their plans to start calling this group of patients in and prioritising their reviews
- 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. Our records reviews of patients with Dementia showed that records we viewed had been coded incorrectly to indicate a medication review had been completed when it had not taken place. We discussed this with the practice and they told us they had taken action following the inspection to review and improve their template and also correct any coding errors.

## Management of people with long term conditions

### Findings

- The practice had implemented processes to offer a structured annual review to patients with long-term conditions, to check their health and medicines needs were being met. However, our record reviews showed that not all patients with long term conditions were being followed up in line with guidelines.

- Our record reviews showed that out of the 5 records that we reviewed for patients with asthma all 5 had had an annual review in the last 12 months. However, all 5 patients had not been followed up following an acute exacerbation of asthma. For 4 patients there either was no care plan, or the practice could not evidence that the plan had been completed.
- The practice did respond to our findings and told us they had processes in place where a GP would task a nurse if a follow up post exacerbation was needed, however they acknowledged this process was not being followed each time.
- From quality and performance information we viewed for September 2022 we saw that the practice was not meeting their lower target of reviewing 45% of all asthma patients and providing a personalised action plan within the last 12 months. Their achievement in September 2022 was 30%. Following the inspection, the practice management team told us, this was a current target and they expected this to improve significantly by the end of year.
- We reviewed 5 records for patients with diabetes. Our review indicated that the practice did have a process for calling patients in for monitoring and for follow up appointments. However, in one of the records we viewed we found all required assessments had not been carried out as part of the annual review.
- From quality and performance data we viewed for September 2022 we saw that the practice had achieved below their lower target for carrying out foot checks on patients with diabetes. Lower target was 50%, actual achievement 39%. Following the inspection, the practice management team told us, this was a current target and they expected this to improve significantly by the end of year.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. For example, staff told us a children and young people asthma group had been set up where practice staff worked with other healthcare professionals to support patients.
- Nursing staff were part of a spirometry multidisciplinary team. The team included a consultant and physiotherapist from the hospital trust (also under the same provider). The aim of the team was to reduce the referral time for patients from when the practice referred the patient for spirometry.
- Staff also referred patients to secondary care teams for specialist diabetes care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice did not always follow 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.
- The practice could not demonstrate that all patients with asthma were offered an asthma management plan.

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	544	610	89.2%	Below 90% minimum

type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	490	557	88.0%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	492	557	88.3%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	491	557	88.2%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	525	613	85.6%	Below 90% minimum

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

### Any additional evidence or comments

We found the practice had appropriate systems in place to call and remind parents about appointments. Staff told us they would share information with health visitors if the patient did not attend after 3 appointments.

The senior management team had implemented a process to enable staff to plan ahead when booking clinics for immunisations. As soon as the practice became aware a patient was pregnant, the patient's details were added to a spreadsheet, this allowed staff to forecast how many appointments would be needed and they could track which appointments had been attended by the patient and child and which were still remaining.

The practice also offered appointments on evenings and weekends to encourage uptake.

The practice worked with the Child health information services to monitor which patients still required vaccinations.

The senior management team told us they were tracking uptake weekly. We saw that information relating to uptake was discussed at Quality and Safety meetings.

The senior management team told us to improve uptake they had reviewed and improved their administration processes to increase the number of appointments available and they had reviewed how patients could make an appointment.

Cancer Indicators	Practice	SICBL average	England average	England comparison
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). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	64.3%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	63.1%	55.8%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	63.5%	57.0%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	50.3%	50.3%	55.4%	No statistical variation

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.

Any additional evidence or comments
<p>The senior management team were aware they were not meeting the minimum targets for cervical cancer screening.</p> <p>From published data we saw that cervical cancer screening had remained at approximately 64%.</p> <p>Staff told us to improve attendance at appointments, nursing staff had been involved in a project to try to identify if there were any particular reasons why patients were not coming in for cervical cancer screening appointments.</p> <p>The project had identified two main reasons for poor attendance. In the younger age group, patients could not attend because of work or caring responsibilities. Staff told us that the senior management team would be looking at how they could make it easier for patients to book an appointment and then attend.</p> <p>In the older age group, patients were less likely to attend because of pain and discomfort. Staff told us they would give patients an option to speak with a nurse first to learn more about the procedure.</p> <p>Staff also told us that the senior management team carried out audits on consultations and patients were contacted as part of the audit to get their views on the appointment to see if any improvements could be made.</p> <p>The practice did not share evidence of these audits with us.</p>



## 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.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

<p>The practice had a comprehensive audit plan for the year, this was agreed in line with the provider's priorities. Learning from audits was shared with staff during Quality and Safety meetings, the staff newsletter, and shared with the provider.</p> <p>The practice shared examples of audits with us that showed an improvement in the quality of care being provided. For example:</p> <p>An audit was carried out to monitor how well the practice was monitoring children on Attention-deficit hyperactivity disorder (ADHD) medicines, to check compliance with NICE guidelines and if an effective shared care agreement with the specialist service was in place</p> <p>An initial audit had been completed in March 2018. A sample of 25 out of 74 patients were included in the audit. The audit showed that 28% of the patients included in the audit had a shared care agreement coded in their record. 26% of patients had weight measurements recorded, 24% had height recorded, 4% had a heart rate and 16% had a blood pressure measurement.</p> <p>A repeat audit was carried out in March 2022 and showed 65% of patients sampled had a shared care agreement coded. 60% had a weight measurement recorded, 55% of patients had a height measurement, 40% had a heart rate recorded by the health care assistant and 40% had blood pressure monitoring done at the practice.</p> <p>The repeat audit indicated that monitoring by practice staff had improved. The audit had also led to other improvements including a re-call being set up for these patients and the booking team was inviting these patients in for regular monitoring.</p> <p>The practice told us about an audit that was carried out yearly since 2016 to monitor antibiotic prescribing and whether an indication had been recorded. The practice had a target of 95% that an indication would be recorded.</p> <p>At initial audit in 2016, 78% of records sampled had an indication recorded.</p>
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At the most recent audit in August 2022, 93% of records had an indication recorded.

The audit also looked at whether prescribing was consistent with local prescribing guidelines. The practice's target was that 85% of prescriptions would be consistent with the guidelines. Data from the audit in August 2022 showed that 85% of prescriptions were issued in line with local guidelines.

## Effective staffing

**The practice was mostly 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.	Partial
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence:	
We saw evidence of completed competency checklists and induction paperwork for new clinical staff.	
Training and compliance with appraisals was monitored by the senior management team and the provider.	
While staff had access to clinical supervision including opportunities to discuss complex patients and seek advice about prescribing there was no formal monitoring of prescribing decisions for all non-medical prescribers. We saw evidence that showed the provider was reviewing their clinical supervision policy, and the senior management were awaiting further guidance.	
The senior management team received information from the provider every 2 weeks with a breakdown of where completion of required training was poor so that they could take relevant action, including reminding staff. We did ask to see a breakdown of all required training; however this was not provided, only a summary of the information.	
From the information provided, we saw that not all staff had completed safeguarding training, basic life support, manual handling or infection, prevention and control training.	

## Coordinating care and treatment

**Staff worked 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.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
Explanation of any answers and additional evidence:	

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence: The senior management team told us, following COVID19 they were not routinely carrying out health checks, as their priority was to work through reviewing patients with existing diagnoses. However, they were offering health checks to all new patients, any patient considered vulnerable, to carers and if anyone requested one.	

## Any additional evidence or comments

Staff told us they referred patients to the social prescribing team (the Living well team). Evidence we viewed confirmed that patients were being referred to the team for additional support. The Living well team were able to support all adult patients at the practice and in particular supported patients over 70 years that had recently been discharged from hospital, supported patients with weight management and at the time of the inspection, the team were involved in a project that was supporting patients with a serious mental illness.

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. <sup>1</sup>	Yes
Explanation of any answers and additional evidence	
Our clinical review of notes where a DNACPR decision had been recorded, identified that where possible the patient's views had been sought and respected, the practice took an MDT approach to decision making, involving the patient and or relatives and carers where appropriate.	

# Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

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

Patient feedback	
Source	Feedback
NHS website	Between November 2021 and October 2022 there had been 5 negative reviews about poor telephone and appointment access and one positive review on the website.

## 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 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 (01/01/2022 to 30/04/2022)	77.8%		79.0%	84.7%	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 (01/01/2022 to 30/04/2022)	74.6%		76.9%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had	87.1%		89.5%	93.1%	Tending towards variation (negative)

Indicator	Practice		SICBL average	England average	England comparison
confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)					
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	44.4%		62.3%	72.4%	Variation (negative)

#### Any additional evidence or comments

The senior management team had discussed the results of the 2021 and 2022 national patient survey. They had worked with an external organisation to identify the main areas of patient dissatisfaction.

The senior management team told us patient satisfaction was poor because of poor telephone and appointment access. They had produced an action plan, with the focus being on improving access, and also thinking about preferred GP and location of appointment.

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

#### Any additional evidence

Staff told us they monitored patient feedback that was left on the NHS website. They also reviewed websites like Google.

The practice was collecting patient feedback at the time of the inspection, about their new appointment system. Patients could submit feedback directly through the system. We saw the senior management team were responding to patient feedback and making changes to improve the new system

For example, some of the patient feedback included that patients were finding it difficult to register for the new system. The senior management in response to this, arranged for extra IT equipment so that staff could help patients register. At the time of the inspection they were trialling this on one of the practices within the PCN.

At the time of the inspection, the practice had received 68 responses through the new appointment system.

## Involvement in decisions about care and treatment

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

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

## 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 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 (01/01/2022 to 30/04/2022)	87.0%	85.2%	89.9%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 739 patients as carers, this was approximately 2% of the patient list
How the practice supported carers (including young carers).	The practice invited carers for health checks and provided evidence to show that 41% of identified carers had attended for health checks since April 2022.
How the practice supported recently bereaved patients.	The practice had reviewed and improved their processes on how they managed and processed information after a patient died. Staff told us the process was co-produced with a recently bereaved patient. Staff told us a new template had been created to capture key details so that relatives only had to tell their story once. The template was then sent to the secretaries, who made all the necessary arrangements and offered signposting to bereavement support services.

## Privacy and dignity

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

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence:  At the main practice and branch site the reception area was a large open area. However, to maintain confidentiality staff told us there were arrangements for patients to be able to speak in confidence if they wished.  There were notices up in waiting room to let patients know if they want to speak to someone in private.  There were breast feeding and baby changing areas.	



## Responsive

## Rating: Requires improvement

At this inspection, we found that not all patients could access care and treatment in a timely way. Although the practice had acted to improve access, at the time of the inspection, they were unable to demonstrate that patient satisfaction had significantly improved.

The practice is therefore rated **requires improvement** for providing **responsive** services.

### Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Partial
Explanation of any answers and additional evidence:	
During our site visit to the main practice, we found there was no hearing loop and the practice could not demonstrate they had fully considered how to support people who had difficulty with their hearing.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am-8pm
Tuesday	8am-6.30pm
Wednesday	8am-6.30pm
Thursday	8am-6.30pm
Friday	8am-6.30pm
Opening times branch practice Lyndon Primary Care Centre:	
Monday	8am-6.30pm
Tuesday	8am-6.30pm
Wednesday	8am-6.30pm
Thursday	8am-6.30pm
Friday	8am-6.30pm
	8am-6.30pm
Extended access appointments on evenings 6.30-8pm and 9-5pm on a Saturday were available at one of the practices within the PCN.	

## 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 had a dedicated home visiting team that worked 8am to 5.30pm Monday to Friday. 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 had a dedicated team that provided care and treatment to patients in care homes or those patients discharged from hospital but needed extra support before they could return home.
- There was a medicines delivery service for housebound patients, arranged through local pharmacies.
- The practice liaised regularly with the community and secondary care services to discuss and manage the needs of patients with complex medical issues.
- Additional nurse appointments were available until 8pm every day at one of the practices within the PCN for school age children and working age people so that they did not need to miss school or work.
- All parents or guardians calling with concerns about a child under 5 years old were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including 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 adjusted the delivery of its services to meet the needs of patients with a learning disability.
- At the branch practice, Lyndon primary care centre, we saw on the ground floor an accessible room that could be used by the public. The room had facilities such as an accessible shower and hoist. The senior management team told us this room was part of a national campaign called Changes Places. The aim of the campaign was for toilets to be installed in all big public spaces so that people including those with a disability could access their community.

### 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 minimize 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)	Yes
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).	Partial
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
Explanation of any answers and additional evidence:	

Staff told us that patient records were coded to help identify if patients had a disability. Written information was available in different languages and large print. However, at the main practice, we found they did not have a hearing loop and the practice could not demonstrate they had fully considered how to support people who had difficulty with their hearing.

To support all patients including those with a disability or with additional needs to access the new appointment system, staff supported patients over the phone or face to face to complete the initial registration process or when making an appointment request.

The senior management team monitored access to the telephone and appointments for all practices within the PCN. They told us that incoming calls had fallen since introducing the new appointment system.

We viewed telephone data for all practices within the PCN, before and after the introduction of the new appointment system and found that the number of incoming calls had fallen from the first week in August 2022 (4259) to the third week in October 2022 (2491).

However, the number of abandoned calls had increased from 3.7% to 27% in this same time period.

The number of calls answered within 4 minutes (the level of service the practice aimed to achieve for 80% of calls) had fallen significantly from 46% to 3.6% and calls answered within 10 minutes had fallen from 68% to 6.3%.

During the inspection visit we viewed live data for all practices within the PCN and found:

10 people were waiting for their call to be answered:

232 calls had been answered

22 minutes was the average waiting time

The waiting time had fallen to 12 minutes later in the day.

42 calls had been abandoned and 5 of those people had called back

The contact centre was open 8-8pm Monday to Friday.

The senior management team told us the target was to answer 100% of calls under 10 minutes and 80% of all calls within 4 minutes, performance data was monitored and discussed each day and they were working towards these goals.

We saw from meeting minutes that we viewed that Contact centre performance was discussed at Quality and Safety meetings, the senior management meeting, and then fed back up through the organisation at the PCN board meetings.

The practice gave us data to show the number of appointments that they had provided each month since April 2022. We saw that the practice as part of the PCN were providing more appointments including extended access appointment than their targets/what they were contracted to provide each month.

The senior management team told us the preferred method for patients requesting an appointment was through the new online system. This was to free up the telephone lines for patients who were not able to use the online appointment system and needed support from staff.

At the time of the inspection, over 20,000 patients had registered for the system.

We saw that to improve telephone access for patients, at busy times for example in the morning between 8 and 10am, all receptionists were expected to answer the phone as well as the contact centre staff.

The practice had a dedicated email address that staff from care homes could use for urgent requests. This was monitored by a dedicated team that supported care homes. If care home staff rang the practice their call would be directed to the appropriate team

Patients wanting to book appointments for cervical cancer screening or long term conditions were given the number for the booking team rather than the contact centre.

### 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 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 (01/01/2022 to 30/04/2022)	8.4%	N/A	52.7%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	29.5%	46.1%	56.2%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	38.4%	48.6%	55.2%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	57.8%	64.8%	71.9%	Tending towards variation (negative)

### Any additional evidence or comments

The senior management team had discussed the national patient survey results. Following the 2021 results they had been working with an external organisation to re-design their appointment system and to find out why patient satisfaction was so low.

The new appointment system had gone live in September 2022. The system asked patients their preferred location to be seen, their preferred clinician and the system determined the level of priority. So that requests could be dealt with in order of urgency The practice could demonstrate that the new system was leading to a reduction in the number of calls coming into the practice, however from evidence we viewed we saw that the number of abandoned calls had increased and they were not meeting their targets for answering calls within 10 minutes.

Source	Feedback
NHS website	Between November 2021 and October 2022 there had been 5 negative reviews about poor telephone and appointment access and one positive review on the website.

## 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.	56
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Partial
There was evidence that complaints were used to drive continuous improvement.	Yes
Explanation of any answers and additional evidence:	
<p>We found there was information on the practice's website on how to complain, however when we visited the practice and branch practice, we did not see any information for patients on how they could submit feedback.</p> <p>The practice had a lead for managing complaints for all practices within the PCN. We saw that the practice had several ways in which a complaint could be submitted, including directly to the practice or through the provider.</p> <p>We found the practice had appropriate systems in place to receive and investigate complaints and then share learning.</p> <p>The new appointment system allowed patients to give feedback directly through the system. We found the senior management team were responding to patient feedback and making changes to processes to improve services further.</p> <p>For example, patients had fed back that there were frustrations with the message when the system was at capacity and patients were not able to make their appointment request. The senior management team had responded by keeping patients better informed about the reasons for why the capacity limit was in place.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Procedure for registering a new patient not followed.	The practice investigated the complaint and spoke with all relevant staff. The staff induction program was reviewed and improved.
Patient was unable to get an appointment.	The complaint was investigated. The practice had acted appropriately, there was no learning or actions for practice staff.
Death certificate process was not followed properly.	The practice investigated the complaint and reviewed and improved their processes to manage death certificate requests.

## Well-led

## Rating: Requires improvement

We found that while the senior management team had implemented processes to deliver safe and effective care, they could not demonstrate that all processes were working as intended.

The practice is rated **requires improvement** for providing **well led** services.

### Leadership capacity and capability

**Leaders demonstrated that they understood the challenges to delivering high quality sustainable care.**

	Y/N/Partial	
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes	
They had identified the actions necessary to address these challenges.	Yes	
Staff reported that leaders were visible and approachable.	Yes	
There was a leadership development programme, including a succession plan.	Yes	
Explanation of any answers and additional evidence: The practice and branch practice were part of a primary care network (PCN). The PCN was part of the Primary Care Community Therapies group within the Sandwell and West Birmingham Hospitals NHS Trust (the provider). The provider had appointed a senior management team to deliver the regulated activities and manage the day to day running of this practice along with other practices that were part of the YHP PCN.  The senior management team was made up of a lead GP, a lead for quality and safety, head of nursing, clinical director for the PCN, directorate lead for the PCN, lead for patient engagement, a business manager, head of acute clinical service and head of finance.  The senior management team met weekly to discuss quality and performance related issues and during the inspection were able to demonstrate that they understood the challenges to providing high quality services and had implemented actions to overcome these challenges.  The senior management team told us their biggest challenge was access and poor patient satisfaction. Following the results of the 2021 national patient survey, the senior management had worked with an external organisation to try to understand why patient satisfaction was so low.  As part of the project the senior management team had looked at all of the policies and processes that were related to access and decided to use a digital forum and adopt a whole system triage. The aim was that patients would have unlimited access and they would not be told that all appointments had gone and they needed to call back another time.  The team had set up a hub from where clinicians would review and triage appointment requests. Clinical staff would either manage requests directly, or allocate them for telephone or face to face appointments. The system went live at the beginning of September 2022.  The senior management team told us they wanted to meet unmet demand and build continuity. When the system went live, they had overstaffed the hub to try to manage unmet demand. However, demand		

exceeded their predictions and at the time of the inspection, the practice was still working through a backlog of requests.

The aim was to deal with the requests as they came in on the day, and planned or anticipated demand was 550-600 requests a day. However, their average was 900-1000 requests a day.

At the time of the inspection, demand was outweighing capacity and the senior management team were reviewing how they would meet this level of demand with current staffing levels.

## 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.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
One team, working together	
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: The senior management team had developed objectives they wanted to achieve between April 2022 and March 2033. These included, focusing on the wellbeing of staff, working through any backlog caused by the COVID19 pandemic, and working with community services and the local NHS trust to improve services for patients  The senior management team met weekly and monitored progress against delivery of the strategy.	

## Culture

**The practice had a culture which mostly supported the delivery of high-quality sustainable care.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Partial
There were systems to ensure compliance with the requirements of the duty of candour.	Yes



When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Partial

Explanation of any answers and additional evidence:

While most staff we spoke with were clear on their roles and responsibilities. We found there was confusion about the role of receptionists. Clinical and non-clinical staff we spoke with told us receptionists have been trained and would be expected to clean up bodily spills. However, the senior management team told us receptionists would not be expected to do this. Our review of staff records indicated that there were gaps in staff immunisations and the practice did not provide evidence of risk assessments to show that risks had been considered and mitigated.

We found evidence of other risk assessments that had not been completed that would support the safety of staff. We also found that while staff were carrying out safe and legal checks on the premises, not all risks had been considered and mitigated, for example fire risk. The practices had also not had a fire drill in the past 12 months.

Not all clinical staff we spoke to felt there was a clear management structure in place. They were unclear on who to go to for professional issues.

The provider had asked staff to complete a staff survey earlier in the year. The senior management team had analysed the results and had acted to improve staff wellbeing. For example, setting up dedicated wellbeing spaces on each site and producing a health and wellbeing newsletter which provided useful information about what services were available to staff to help improve health and wellbeing.

The practice did not provide evidence of equality and diversity training for staff to demonstrate that staff were provided with relevant training on treating people equally.

Following the inspection, the practice management team told us, Equality and Diversity training was included in the required training for all staff and at the time of the inspection only 1 staff member had not completed this.

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

Source	Feedback
Staff we spoke with	Most staff we spoke with felt supported by immediate and senior management. They told us leaders were visible and approachable. They felt valued and listened to by management. Staff told us the senior management team were forward thinking and proactive in supporting training needs.

#### Governance arrangements

#### Governance arrangements required improvement.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	partial
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The senior management team had set up monthly quality and safety meetings to discuss safeguarding concerns, incidents, complaints, outcomes and learning from audits, and to discuss other areas of performance and risk.</p> <p>We also found there were appropriate channels for information to flow through the organisation. For example up to the provider or down to all staff.</p> <p>We found that some of the governance systems implemented to monitor how effective processes were or how well processes were being followed, required improvement. For example, the system used to monitor if coding was correct was not adequate. The practice had audited a sample of 413 letters that had been coded since January 2022. Staff told us they received between 2500 and 3000 letters each week that required coding. This suggested that the audit included less than 1% of the total number of letters coded for that time period.</p> <p>Following the inspection, the practice management team told us since January 2022, they had audited 608 letters, 95.4% of which were coded correctly and 1.64% coded incorrectly.</p> <p>The systems used to monitor that tasks and bloods results had been responded to within agreed times scales were not well followed. We found tasks and letters that had not been actioned and a 2 week wait referral that had not been sent.</p> <p>We also found that not all staff could access the provider's IT systems, including the system to record incidents. The senior management team told us this had been raised with the provider.</p> <p>During the inspection staff were able to tell us how they accessed policies. From meeting minutes we viewed, we saw that staff were not able to access the provider's system to view polices, and they had all been uploaded to the practice's local system for staff to view immediately before the inspection. The senior management team had raised this with the provider.</p> <p>We found systems used to monitor that patients received appropriate monitoring before prescriptions were issued were not comprehensive and medication reviews did not always consider all of the patient's needs.</p> <p>Systems used to monitor compliance with safety alerts were not comprehensive, The practice could not demonstrate that all relevant safety alerts had been responded to.</p> <p>We found that not all staff had been provided with access to safeguarding information within patient records.</p>	

## Managing risks, issues and performance

### Processes for managing risks, issues and performance required improvement.

	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.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Partial
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The provider could not demonstrate that all relevant risk assessments for the premises had been carried out including fire risk assessments or that all actions following risk assessments had been carried out.</p> <p>We were not provided with action plans following IPC audits and the practice could not demonstrate that relevant actions had been taken.</p> <p>We found that safe and legal checks used to monitor premises related risks, in the absence of formal risk assessments, were not adequate and did not identify all potential risks.</p> <p>We were provided with summary information of how compliant the practice staff were with required training; however the information did not go into detail and did not show if staff had completed fire training or any training for major incidents. We saw that not all staff had completed safeguarding training, infection control or basic life support training.</p> <p>The senior management team had implemented processes to monitor staff performance. We saw that most staff had received a yearly appraisal, and we saw evidence of audits on GP records to monitor for quality of record keeping. We found that staff had access to support from GPs when making clinical decisions, however the practice could not demonstrate how they monitored the prescribing decisions of all non-medical prescribers.</p>	

## 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.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence:	

All complaints and incidents were discussed at monthly quality and safety meetings, the team would look for trends, or for action that was required for the whole organisation. Learning or actions were shared with staff through meetings and the monthly newsletter

A representative from the quality and safety meeting attended the provider's quality and safety meetings at group level every month so that learning could be shared with the wider organisation

The senior management team monitored performance weekly They looked at what they needed to provide contractually and how well they were meeting these targets.

The senior management team told us a monthly report was produced for the provider including what actions they needed to carry out in order to meet targets.

We found the senior management team were aware of where performance was below target and they were able to tell us what actions they would be taking to improve performance.

## 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.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Staff are supported to work remotely where applicable.	Yes
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.	Yes

The practice had an active Patient Participation Group.	No
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the time of the inspection the practice did not have a patient participation group. The senior management team told us of their plans to get this re-started.</p> <p>The practice had engaged with patients before introducing the new appointment system. They had held 2 face to face sessions in the community. They told us the sessions were well attended with 100 patients attending in total. The sessions gave patients the opportunity to voice their concerns and struggles and ask questions.</p> <p>The practice also promoted the new system through the website and wrote to all patients about the new system and what to do if they could not access the internet</p> <p>The practice continued to collect patient feedback on the new appointment system and respond to it, to make further improvements to access or on how information was shared with patients.</p> <p>The practice had published their public engagement strategy in 2019-2022 and were looking at how to set up a network of patients (patient participation group).</p> <p>Staff told us they were able to share feedback and concerns with the senior management team.</p> <p>The lead GP held meetings with the provider and other GP leads of practices that were managed by the provider to plan for the future and discuss their patient population's needs.</p>	

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The senior management team demonstrated that they had systems in place to investigate and learn and from incidents and complaints and that learning was shared with all staff to improve services.</p> <p>Staff gave us examples where learning from a complaint or incident had led to significant improvements in a process. For example following an incident the senior management team reviewed and improved their sickness reporting procedures. Following a complaint, the practice improved their processes for managing requests for death certificates.</p> <p>We saw evidence of a comprehensive audit plan for the year and that learning from clinical audits was shared with relevant staff. From clinical audits we viewed, we saw there were improvements in the quality of care provided to patients.</p>	

## Examples of continuous learning and improvement

The senior management team were aware that reorganisation of services needed to happen to better support their patient population and gave us examples of how working as part of a large organization (a hospital trust) benefited patients.

The social prescribing team (The Living well team) were involved in several projects at the time of the inspection that aimed to offer personalised care for patients and improve their overall health and wellbeing. The team had been nominated by the provider for an award in recognition of the work they were doing and the team were successful in making it into the top 4, however did not win the award.

One of the projects they were involved in at the time of the inspection was a project where staff worked with the hospital trust to support patients over 70 years of age after they had been discharged from hospital. Staff contacted patients and were able to ensure that patients had everything in place at home to support them following their discharge from hospital.

The team had immediate access to clinicians, they were able to view and book appointments and had access to the patient's records, so that their actions and recommendations could be seen in real time by clinicians.

Another project the team were involved in was supporting patients with a serious mental health illness. 50 patients had been selected to be part of the pilot project. Staff contacted patients every 3 months to support with social issues, accompany them to appointments, or call them weekly if that is what the patient wanted.

Staff asked and recorded measurable outcomes so that progress with the patients' health and wellbeing could be monitored.

The senior management team were trialling the project with this particular patient group first, as they had identified that this patient group often were high service users of primary and secondary care and if successful, they planned to roll it out to other patient groups with complex needs

Early results of the project were positive and were identifying challenges that clinicians were not previously aware of.

The practice also provided care to patients in integrated community step-down beds. This is where patients had been discharged from hospital but were not ready to go home yet and needed additional support. This service was led by advanced clinical practitioners with support from a GP.

This team were nominated by the provider for the clinical team of the year award, however, unfortunately did not win.

Staff told us about a pilot study, carried out over 6 months, involving diabetic patients, where a sensor was inserted into the patient's arm. The sensor allowed the patient to more easily monitor their blood sugars and amend their insulin dose. Staff told us all patients in the pilot improved their diabetes care. At the time of the inspection a total of 70 patients were using the sensor. Staff told us they were thinking about how to expand this for house bound and care home patients, and patients with learning disabilities.

Staff also told us they were finding that patients were more engaged in lifestyle changes, because they could see the information immediately and the benefits those lifestyle changes were having

Staff told us they were working with the hospital trust so that children diagnosed with type 1 diabetes would either leave hospital with the sensor get it soon after being discharged.

#### 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 SICBL 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 SICBL 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.