

# Care Quality Commission

## Inspection Evidence Table

The Acocks Green Medical Centre (1-9104613778)

### Inspection Date:

Date of data download: 14/07/2023

## Overall rating: Requires Improvement

At this inspection we have rated the practice as requires improvement overall because processes relating to the care and treatment of patients were not always consistently and fully completed.

### Safe Rating: Requires Improvement

At this inspection we found that the practice was not consistent in its prescribing and monitoring of all high-risk medicines. We have therefore rated the practice as requires improvement for providing safe services.

#### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Partial
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	Yes

midwives and social workers to support and protect adults and children at risk of significant harm.	
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had systems in place to safeguard children and vulnerable adults from abuse. This included updated policies and procedures, which were accessible to all staff on the practice shared drive and dedicated administration system.</li> <li>• The practice had a designated GP safeguarding lead for adults and children, who had completed level 3 safeguarding training to support them in this role.</li> <li>• All staff received up-to-date safeguarding and safety training appropriate to their role and knew how to identify and report concerns.</li> <li>• The practice maintained safeguarding registers. We saw evidence of reconciliation of the registers. Alerts were put on the records of patients identified as being at risk from abuse. This included children on the child protection register, children of concern and looked after children. It was noted and discussed with the GPs that families of patients identified as at risk were not always linked on the patient administration system or had alerts on their records. Action was taken by practice staff to address this.</li> <li>• The location of the practice was identified as a low risk area for FGM. Discussion with practice clinical staff demonstrated a good understanding of the risks of FGM within their population and a process was in place to take the action needed to safeguard those at risk.</li> <li>• We saw that Disclosure and Barring Service (DBS) checks were undertaken for all staff, in line with the practice policy. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Our review of the records for 2 newly appointed staff confirmed DBS checks had been completed and the outcome received for both staff prior to employment.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• We reviewed the recruitment files for two members of staff and found that safe recruitment practices had been followed.</li> <li>• Both files were organised so that relevant documents were readily and easily accessible. However, we identified a lack of detail in recruitment interview forms to demonstrate discussions and responses to the interview questions to support the decision to employ the staff. The practice manager acknowledged this and we were reassured that action would be taken.</li> <li>• Staff records showed that all staff were up to date with immunisations such as tetanus, diphtheria, polio, measles, mumps and rubella (MMR) and hepatitis B.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes
Date of last assessment: June and July 2023	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 16/09/2021	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Practice staff ensured that health and safety risk assessments were carried out to maintain the safety of those who used the service.</li> <li>The practice had appropriate safety policies, which were regularly reviewed and communicated to all staff.</li> <li>The practice had two named fire marshals who had completed the required training. Staff training records showed that staff had received training related to health and safety and fire safety.</li> <li>Systems were in place to check, maintain and calibrate equipment used to support patient care and treatment at the practice. Equipment was checked annually to ensure it was safe to use. The last checks were completed in July 2023.</li> <li>Portable Appliance Testing (PAT) was carried out in January 2023 on electrical appliances and equipment to ensure they were safe to use.</li> </ul>	

### Infection prevention and control

#### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit: 26/05/2023	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At our site visit to the practice, we found the premises were visibly clean, tidy and well presented.</li> <li>The practice employed a cleaner who worked 20 hours per week. A cleaning schedule was in place. Ongoing monitoring and audit of the standard of cleaning carried out was completed by the practice manager.</li> <li>We found that a full infection prevention and control audit had been completed but the format of the report did not make it clear what standard the practice had achieved and if there were any areas that needed to be improved.</li> </ul>	

- Hand hygiene audits had been completed as part of infection prevention and control monitoring (IPC).
- Training records showed that all staff had completed IPC training.

### Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had a regular GP locum working at the practice to support the continuity of care of its patients. The practice locum pack had been updated and contained useful information to support staff working at the practice on a temporary basis. Information included in the pack covered topics such as health and safety and relevant contact details.</li> <li>• The induction system documentation showed that it was also designed to address the needs of temporary staff.</li> <li>• Staff were aware of their responsibilities if presented with an emergency. For example, the deterioration of patients while waiting to be seen by a clinician had been discussed with staff. Staff spoken with were aware of the signs to observe for, symptoms to ask about, and the action to take.</li> <li>• Staff had access to emergency medicines and equipment in the event of a medical emergency and knew where to find them when needed.</li> <li>• Basic life support and sepsis training were part of the practice's mandatory training requirements.</li> </ul>	

**Information to deliver safe care and treatment**

**Staff had the information they needed to deliver safe care and treatment.**

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Our clinical searches found that clinical records were mostly well maintained.</li> <li>• The practice had inherited a backlog of patient records that needed to be summarised. The practice staff had completed a risk assessment to support the implementation of a plan to mitigate the level of risk. The plan included assigning a dedicated group of staff to complete the task by December 2023. The practice manager was assured that they were on target to meet this date.</li> <li>• Systems were in place to share information about patients electronically with other services. For example, the practice shared relevant information with out of hours services so they were aware of any concerns and able to support continuity of care.</li> <li>• Referral systems in place enabled staff to be proactive in following up and checking that patients received timely appointments.</li> <li>• Test results were reviewed by the GPs, records reviewed showed that these were managed in a timely way. Our remote review of test results showed that all were current and up to date.</li> </ul>	

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.64	0.93	0.91	Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2022 to 31/03/2023) (NHSBSA)	3.9%	7.1%	7.8%	Variation (positive)
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 (01/10/2022 to 31/03/2023) (NHSBSA)	4.34	5.17	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	98.3‰	115.7‰	129.8‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.84	0.58	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	11.9‰	7.9‰	6.8‰	Variation (negative)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	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.	NA
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes

Explanation of any answers and additional evidence, including from clinical searches.

- National prescribing data showed that the practice prescribing was mostly in line with other practices locally and nationally. There was one indicator that showed the prescribing rate of medicines to treat and manage a patient's behaviour, mood, thoughts, or perception was higher than other practices. The providers were aware of this and ensured their programme of audits provided the ongoing monitoring needed to identify where improvements in prescribing habits were required. Comparison with the previous year's (01/10/2021 to 31/03/2022) data for these medicines showed that prescribing rates although still higher than other practices had decreased from 13.1‰ to 11.9‰.
- Our clinical searches for patients prescribed more than one medicine showed that consultation records were detailed to demonstrate that medicine reviews had been completed.
- The practice clinical team regularly reviewed its prescribing habits with the support of the medicine's management team. The reviews included the prescribing practices of non-medical prescribers. At this inspection we found that there were some gaps in the systems for the safe management of all medicines.
- As part of our inspection we reviewed a sample of patients on Disease-modifying antirheumatic drugs (DMARDS) and high-risk medicines that required regular monitoring due to the risk of side effects. Information available showed that 9 of the 10 patients had blood tests completed within the required 3 month period. One patient had not received the required monitoring and records for a further patient showed the day of the week the medicine should be taken was not included on the prescription as recommended by best practice guidance to mitigate the risk of toxicity due to daily dosing. These findings were discussed with the GP clinicians. They explained that the patient identified as not monitored was being treated and monitored by the hospital and explained that they did not have access to this particular hospital results system. Action taken by the practice staff included formally requesting the results, which were recorded and coded into the patients records. The other patient was contacted and their prescription amended to ensure that both the dose to be taken weekly and the day of the week the medicine should be taken was indicated. At the inspection site visit we saw evidence that both issues had been addressed.
- We found 2 patients had been prescribed Lithium, a high-risk medicine used to control mood disorders. We found that the monitoring of one of the patient's was up to date and test results were filed and recorded in the patient records. The records for the second patient showed that monitoring had not been carried out. A discussion with the clinicians identified that the patient was currently an inpatient in hospital for more than 6 months. The practice clinicians had not been involved in prescribing this medicine for the patient over this period.
- Our clinical searches identified 2 patients prescribed Metformin (A medicine used to treat patients with Type 2 Diabetes). We found that both patients records showed the results of a specific test to determine renal function was below the National guidance recommended range, within which the medicine could be safely prescribed due to the risk of low renal (kidney) function. The records we reviewed did not reference a referral had been made to a renal specialist or other appropriate intervention. Information and evidence from our discussion with the clinicians showed that one of the patients had not been taking the medicine for over 3 months.



This had been stopped when the clinicians saw that the patient’s renal function had decreased. The patient had also been referred to relevant secondary care specialists. The second patient was reviewed at the time of the inspection, their medicine was discontinued and the patient referred to the local renal and diabetic teams.

- Following the remote inspection the clinicians carried out an audit of their medicine monitoring processes to ensure the current systems in place were appropriate and met the needs of current guidance and evidence based practice. The outcome of the audit resulted in the update of the practice systems for the ongoing monitoring of medicines. This included for example, the practice pharmacist carrying out regular medicine audits to identify patients who had the potential to be missed or needed to be recalled for planned medicine reviews.
- It was discussed with the clinicians that the patient information system needed additional software downloaded to ensure they had access to and could respond promptly to all alerts generated by the system linked to patient test results and treatment. The system was updated by practice staff at the time of the inspection.
- There were appropriate arrangements in place for the management of vaccines and for maintaining the cold chain. We saw fridge temperatures were routinely monitored and vaccines reviewed at random were in date and stored appropriately.

**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:	3
Number of events that required action:	3
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• There was a system for recording and acting on significant events.</li> <li>• Practice staff confirmed that significant events had been discussed at practice meetings. Staff we spoke with knew how to report incidents and significant events and could share examples of incidents that had occurred.</li> <li>• Staff told us that incidents were logged and reported to the practice manager.</li> <li>• Documented information showed evidence of learning and dissemination of information to staff.</li> <li>• The minutes of meetings showed that significant events / incidents were a standing agenda item at all meetings. The minutes were detailed and contained details of the discussion, learning and the agreed action to be taken.</li> </ul>	

Event	Specific action taken
<p>A patient diagnosed with a learning disability was given the flu vaccination on 2 separate occasions in the same year.</p>	<ul style="list-style-type: none"> <li>• At a visit to the GP practice the patient was asked about the flu vaccination and agreed to have the vaccination, which was then given by the GP. It was later identified that the GP had missed the notification in the patient records from the pharmacy stating that the vaccine had been given to the patient 2 months previous.</li> <li>• The patient was checked to ensure they had not come to any harm and their support workers were informed.</li> <li>• The incident was discussed with the clinicians. The importance of checking patient records and including the patients' support worker in the discussion with the patient if appropriate.</li> </ul>

Safety alerts	Y/N/Partial
<p>There was a system for recording and acting on safety alerts.</p>	<p>Partial</p>
<p>Staff understood how to deal with alerts.</p>	<p>Yes</p>
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• We found that the practice had a system in place to act on alerts which may affect patient safety.</li> <li>• Safety alerts were shared with relevant staff. Staff received instructions on any action they may need to take. There was a lead member of staff who ensured that safety alerts were acted on and details of the action taken was recorded. Where needed clinical and practice procedures were reviewed and updated for all high risk medicines and planned changes were discussed and agreed with all clinicians.</li> <li>• We saw examples of actions taken in response to medicine safety alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA).</li> <li>• A random review of a MHRA alert was related to medicines that could increase the risk of abnormalities in pregnancy. We identified 33 patients prescribed one of these groups of medicines. We reviewed 3 of the records and found no evidence that these patients had received the recommended advice about the risks associated with these medicines for those who were at an age where they could get pregnant. Following the inspection the practice clinicians evidenced that they had taken appropriate action to mitigate the level of risk this could present. This included the outcome of a review undertaken to identify if there were any other patients who had not received the advice. A decision was made to send all patients prescribed these medicines an initial text message followed by letters relevant to the medicine prescribed to further highlight the risks to pregnancy for those in childbearing age groups. Patients were also offered a face to face or telephone discussion if needed.</li> </ul>	

## Effective

## Rating: Requires Improvement

At the inspection in July 2022 the practice was rated as requires improvement for providing effective services. We found that the uptake of childhood immunisations was below the WHO target and national minimum. More significantly, the cervical screening uptake had remained significantly below the local and national averages since 2016.

At this inspection, we found that those areas previously regarded as requires improvement showed that childhood immunisation uptake had improved. For example, there were increases of between 1.4% and 6.1% in 4 of the 5 child immunisation indicators tabled in this report however, the percentage of children aged 1 who had completed a primary course of required immunisation had decreased from 91.9% to 83.9%. Data for cancer screening showed that there was a decrease in the uptake of cervical cancer screening and the 3 year coverage for breast cancer screening identified a significant decrease from the previous year. The practice therefore remains 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 assessed, and care and treatment were mostly delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Yes

The practice prioritised care for their most clinically vulnerable patients.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Our review of the practice clinical system identified appropriate management of patients care and treatment who were at risk of long-term conditions.</li> <li>• Care pathways and protocols used at the practice were aligned to national guidance. This included guidance from NICE (The National Institute for Health and Care Excellence) and MHRA (The Medicines and Healthcare products Regulatory Agency).</li> <li>• Our clinical searches found that most patients had their care and treatment appropriately assessed. We identified some gaps relating to completeness of health reviews. For example, we found 14 of 286 patients with an asthma diagnosis had received two or more courses of steroids (also an indication of poor asthma control) in the last 12 months. Records showed that these patients had all received relevant reviews relating to their health condition. One patient was eligible for a steroid card but this had not been issued in line with National guidance. The patient was contacted, issued with a steroid card and advised of the importance of having this with them at all times. Changes made by the practice team also included adding alerts to patients records as a reminder to clinicians to issue the card.</li> <li>• Other gaps identified were mainly related to the management of medicine reviews.</li> </ul>	

## Effective care for the practice population

### Findings

- Patients received a full assessment of their physical, mental and social needs, when appropriate.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice had systems in place for recalling patients with long-term conditions to attend for their annual review to check their health and medicines needs were being met.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Our clinical searches included a review of patients with the potential of a missed diagnosis of diabetes based on blood test results. We identified 5 patients with the potential for a missed diabetes diagnosis and reviewed 3 patient records. Our findings showed that potential patients were identified by the clinicians but repeat blood tests to confirm diagnosis within the national guidance of 2 to 12 weeks had not been completed. We found that a diagnosis of diabetes could not be confirmed for two of the three patients due to the length of time taken to repeat the blood tests. We also found that patients records were not all appropriately coded to confirm their diagnosis. This was discussed with the GPs who were able to confirm and evidence that 3 of the 5 patients had been appropriately coded as Type 2 diabetics. For the remaining 2 patients' action had been taken to recall both patients.
- We found there were 408 patients on the practice diabetic register of these 27 were identified with diabetic retinopathy (a complication of diabetes) and high blood glucose (sugar) levels. We reviewed the records for two patients and found minor issues related to an overdue medicine review for 1 of the patients. The patient records showed and clinical staff confirmed that the patient was non-compliant with their planned care and treatment for example, not taking medication and non-attendance at diabetic retinopathy screening appointments. All attempts were and had been made by practice staff to recall the patient for a full review. Overall however, we found that both patients had received diabetic reviews over the year, with appropriate interventions made at each review.
- The practice had a register of 20 patients with late stage Chronic Kidney Disease (CKD). We identified that 5 of the 20 patients had not had specific blood tests monitored in the last 9 months. This was followed up by the GPs who carried out their own search to assure themselves that all patients tests and reviews were up to date.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	52	62	83.9%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	53	66	80.3%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	54	66	81.8%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	57	66	86.4%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	62	78	79.5%	Below 80% uptake

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

### Any additional evidence or comments

- The published child immunisation data for the period April 2021 to March 2022 showed that the practice had not achieved the World Health Organisation (WHO) uptake target of 95% (the recommended standard for achieving herd immunity).
- Comparison of the practice performance showed it was below the uptake target of 90% in 4 of 5 indicators. However a comparison of the data showed an overall increase in uptake of between 1 and 6% over the past year in all indicators except for the percentage of children aged 1 who had completed a primary course of immunisation indicator.
- Practice data also showed that the uptake for the percentage of children aged 5 who had received immunisation for measles, mumps and rubella although under 80% had increased by 7% on the previous year's uptake.
- The practice had systems in place to support increasing the uptake of childhood immunisation. Vaccinations were offered opportunistically when parents brought their child to the practice for any other reasons.
- Practice staff worked with and were supported by other organisations such as the local Integrated Care Board (ICB) to educate parents or guardians about the importance of childhood immunisation.
- Leaflets explaining the benefits of childhood immunisations were available for parents in different languages.
- Follow up calls and recalls were made to parents or guardians of children not brought for their appointment. Staff also notified the health visitor of any children who failed to attend after three occasions.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	6.7%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	51.7%	N/A	70.3%	N/A
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 31/12/2022) (UKHSA)	52.4%	N/A	80.0%	Below 70% uptake
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 31/03/2022) (UKHSA)	37.5%	53.2%	54.9%	No statistical variation

### Any additional evidence or comments

- Data showed that cervical screening uptake at the practice was below the England uptake of 70% and target of 80%. The uptake had also decreased slightly (2.3%) over the past 9 months.
- The importance of cervical screening was discussed with patients at every opportunity. Practice staff told us that they had proactively contacted patients who were overdue or had not attended their appointment and there were systems in place for recalling patients who failed to attend appointments.
- The female GPs and advanced nurse practitioner (ANP) carried out cervical screening both at planned appointments and opportunistically. For example, screening was offered to mothers when they brought their child/children to the practice for immunisations or other appointments. Alerts had also been placed on patients' records to prompt all staff that the procedure was due or had not been carried out.
- Data also showed a decrease in breast cancer screening for patients aged 50-70, screened for breast cancer in the last 36 months (3 year coverage). This was a significant decrease when compared to the previous year. The uptake for March 2021 and April 2022 was 6.7% compared to 48% in the previous year. Practice staff were not able to confirm if the recent data was accurate.
- The practice national cancer screening data for bowel cancer and new cancer cases treated resulting from a 2 week wait showed an increase in uptake.
- Practice staff were aware of the challenges presented by their patient population. They had identified the need for educating patients on the importance of cervical and other cancer screening programmes.
- The practice clinical staff encouraged and advised patients about the importance of taking part in the cancer screening programmes. Written information was available to support and educate patients in making informed choices.

### Monitoring care and treatment

**The practice had a programme of quality improvement activity and 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.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ul style="list-style-type: none"> <li>• The provider had a structured programme of medicine prescribing audits. Audits were carried out to monitor and review medicine prescribing at the practice in response to safety alert notifications. Following the inspection the programme was reviewed and updated to ensure that the audits included a review of MHRA guidance and could demonstrate that prescribing and monitoring of medicine</li> </ul>	



practices was within national guidelines. The practice GPs also identified that the audit of some prescribed medicines needed to be completed more frequently.

- Audits completed for example, included reviewing the prescribing of a medicine called Methotrexate. This is one of a group of medicines used to treat inflammatory conditions such as rheumatoid arthritis which has the potential for serious side effects. Updated national guidance introduced new measures to prompt healthcare professionals to record the day of the week that the medicine should be taken in full on the prescription. Information should also be given to patients on how and when the medicine must be taken and the risks of overdose.
- The audit was carried out to ensure that clinicians working at the practice were following the guidance to reduce the potential risk of overdosing. The first cycle of the audit was carried out in June 2022 and reviewed all patients prescribed the medicine in the previous 6 months. Seven patients were identified, the results showed that all the patients had the day of the week the medicine should be taken detailed in full on the prescription.
- Practice staff repeated the audit in June/July 2023. Eight patients were identified as having been prescribed Methotrexate. The findings showed that 1 patient had the medicine stopped following advice received from the secondary care sector. Six patients had the day of the week they should take the medicine written in full on the prescription. Prescribing details for the remaining patient showed that they were not in line with the guidance as the day of the week had not been recorded. This was followed up by the practice clinicians and appropriate action taken.
- The practice planned to complete this audit annually or sooner if required.
- Further audits carried out across the organisation looked at the prescribing of broad spectrum antibiotics to ensure this was in line with formulary guidelines.

### Effective staffing

**The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.**

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes

Explanation of any answers and additional evidence:

- Training records we reviewed showed that staff had completed the provider's relevant mandatory training and training applicable to their role in a timely manner.
- The practice appraisal process included assessing and updating staff competencies in their individual roles. The records we reviewed showed a two way conversation had taken place and that staff were able to discuss their learning and development needs.
- We saw that the advanced nurse practitioner took responsibility for their professional development and were supported to meet the requirements for professional revalidation.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.

### Coordinating care and treatment

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

	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:	
<ul style="list-style-type: none"> <li>• Systems were in place to share information about patients electronically with other services.</li> <li>• Relevant information was shared with out of hours services to support continuity of care.</li> </ul>	

### 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 practice was part of a primary care network, as a team they were developing a diverse workforce of clinical support professionals and social prescribing support to meet the needs of the local population.
- NHS health checks were carried out to identify patients at risk of developing long-term conditions, so that early interventions could be undertaken to improve the lives of patients.

### 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.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Practice staff were aware of legislation and guidance when considering consent and put this into practice when providing care and treatment to patients.</li> <li>• The practice clinicians used both Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and ReSPECT forms. We saw that information had been shared with relevant agencies, which included the out of hours service and relevant community services.</li> <li>• Copies of the completed and signed forms were given to patients and a copy was available in the patient's electronic records.</li> <li>• Our clinical searches identified that where DNACPR decisions had been recorded they identified where possible that the patients' views had been sought and respected.</li> <li>• The practice clinicians carried out after death reviews and audits.</li> </ul>	

# Caring

**Rating: Good**

## Kindness, respect and compassion

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

	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: <ul style="list-style-type: none"> <li>We spoke with two Patient Participation Group (PPG) members during the inspection. Overall, the members were positive about the practice and the services they received. However, expressed concerns about access.</li> <li>There was a formal agenda, to encourage patient engagement. This included actively working with the PPG to listen and address concerns raised by patients.</li> <li>The practice noticeboards were updated using a themed concept to keep patients informed and updated about changes at the practice.</li> </ul>	

Patient feedback	
Source	Feedback
Patient Participation Group (PPG)	We spoke with 2 patients; both were representatives from the practice's PPG. They expressed satisfaction with the care and treatment they received.
NHS Website	There were 5 reviews posted on this website since the last inspection carried out in July 2022. The main comments made were about access. Other comments made related to care, highlighted concerns about the issuing of prescriptions.
Healthwatch Birmingham	The practice had been given a 2.5 rating based on 15 reviews for the period April 2021 to June 2023. Five of the reviews had been made over the past 12 months. Feedback about care and treatment were mostly positive. Patients commented that that the doctors were good and referrals were made in a timely manner. However, comments made in reference to receptionists were not always positive.

## National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)	75%	80.4%	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 (01/01/2023 to 30/04/2023)	72%	78.4%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2023 to 30/04/2023)	90%	90.5%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	53%	65.0%	72.4%	Tending towards variation (negative)

### Any additional evidence or comments

- The practice results for the national patient survey published in July 2023 showed improvements in patient's responses in 3 of the indicators above.
- The practice had lower scores for the question relating to patient's overall experience of their GP practice. Comments made on the NHS and Healthwatch websites indicate that patients continued to have strong feelings about the change in the practice ownership. The practice management team had tried and continued to address this through improvements in communication with patients. This included, themed noticeboards which were regularly updated to focus and inform patients of any planned changes at the practice, community events / celebrations and health education.

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

**Involvement in decisions about care and treatment**

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The two PPG patient representatives we spoke with told us how positive attempts had been made to improve communications between the practice and patients.</li> </ul>	

Source	Feedback
Interviews with patients.	The PPG members were both positive about the care and treatment they received at the practice. They told us that they felt included and received sufficient information to understand their care and treatment.

**National GP Patient Survey results**

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who 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%	86.3%	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: <ul style="list-style-type: none"> <li>In the absence of an interpreter most of the staff working at the practice were able to speak with patients in their first language.</li> </ul>	

Carers	Narrative
Percentage and number of carers identified.	At the time of the inspection the practice provided a service to a population of 5,723 patients. There were 131 patients registered as carers at the practice. This represented approximately 2.3% of the practice population. Carers were encouraged to register as a carer with the practice. There was a dedicated carers notice board and an information pack available in the reception area. These contained details on the support and services available to carers.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> <li>• Carers were offered an annual health check.</li> <li>• Carers were offered an annual flu vaccine.</li> <li>• The practice made every effort to identify young carers.</li> <li>• All carers had access to the Birmingham's carers hub.</li> </ul>
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> <li>• The practice maintained a register of patients who received end of life care.</li> <li>• Families who had a bereavement were contacted and offered an open invitation to attend the practice if they wanted, advise or to discuss anything further.</li> <li>• The practice had bereavement packs which included information and details of support services available for the family.</li> </ul>

### 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Staff recognised the importance of and took measures to ensure people's dignity and respect when using the service.</li> <li>• Staff knew that if patients wanted to discuss sensitive issues or appeared distressed, they could offer them a private room to discuss their needs. There was information at reception alerting patients to this.</li> <li>• Confidentiality was covered as part of new staff induction and staff signed a confidentiality agreement as part of their employment.</li> </ul>	

## Responsive

## Rating: Requires Improvement

At this inspection we have rated the practice as requires improvement for providing responsive services. Patients had concerns about being able to access the practice easily. This was reflected in concerns the Care Quality Commission (CQC) received from patients, the results of the National GP Patient Survey results, which showed a negative variation when compared to other local practices and comments made on review websites.

### Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice management team had plans in place to improve appointment availability at the practice. Plans included recruiting additional staff who could meet the clinical needs of patients. New staff to be recruited included a GP and a health care assistant.</li><li>• The practice had a team of clinicians to provide a range of appointments. This included a pharmacist and an advanced nurse practitioner.</li><li>• Appointments were available during the morning and afternoon with clinicians.</li></ul>	



<b>Practice Opening Times</b>	
<b>Day</b>	<b>Time</b>
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	8am – 1pm and 2pm – 6.30pm
Tuesday	8.30am – 1pm and 2pm – 6.30pm
Wednesday	8am – 1pm and 2pm – 6.30pm
Thursday	8.30am – 1pm and 2pm – 6.30pm
Friday	8.30am – 1pm and 2pm – 6.30pm

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

- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice had opted out of providing cover to patients in their out of hours period. During this time, services are provided by Birmingham and District General Practitioner Emergency Rooms (BADGER) medical services. Patients are also directed to the BADGER service when the practice is closed Monday to Friday between 1pm and 2pm. The BADGER service refers any messages received during this time to the practice.
- The practice held a register of patients living in vulnerable circumstances including people who misused substances and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

**Access to the service**

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	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).	Yes
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had continued to receive negative feedback in relation to patient access to the practice. This feedback was evident in the GP National Survey results.</li> <li>• Patients had complained that they had struggled to access services through the telephone lines. The management team had tried to address this by reviewing the staff structure, allocation of workload and introducing additional clinical support to increase patient access to consultations. For example, the number of staff answering the phone had increased from 2 to 3 and at busy times a fourth person usually the deputy practice manager supported reception staff.</li> <li>• The new telephone system allowed the practice to monitor call volume, queue status and the quality of call conversations. The deputy manager carried out audits and advised that the outcome of these showed that there had been some improvement in telephone access for patients. The information available showed an analysis of the quality of call and feedback given to the staff involved where concerns were identified. However, there was no analysis provided to evidence for example, of the number of calls dropped or abandoned, which could support the practice in providing evidence that demonstrated improvements in patients access to the practice.</li> </ul>	

## National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	23%	39%	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)	30%	46%	54%	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)	34%	47.1%	53.2%	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)	59%	68%	71.9%	Variation (negative)

### Any additional evidence or comments

- Patient responses in the national patient survey were all negative about access to the practice. Although there had been an increase of between 5 and 15% in patient satisfaction the results remained significantly lower than both the local and England averages.
- Following the last inspection in July 2022 the care quality commission (CQC) had received two complaints about access to the practice. Concerns raised told us that they either had to wait for long periods on the telephone or were unable to get an appointment.
- The practice was aware of patient concerns about access and had introduced new systems to address this. For example, the practice used an appointment texting system to remind patients about their appointments.
- The practice manager shared audit data that had been collated to demonstrate the number and type of appointments offered and taken up by patients. For example, over a 12 month period 13,906 face to face appointments were available between July 2022 and June 2023, 13,187 (94%) of these were booked. Data showed that 1,756 (13%) did not attend their appointment. There was no evident analysis of the data to demonstrate whether the number of patients provided with an appointment were in line with the recommended ratio guidance for the practice list size.

- The practice was also supported by its local Integrated Care Board, General Practice Peer Support Team (GPPST) to complete an 'Access Improvement Toolkit'. The toolkit was designed to support practice staff to identify areas that presented a challenge to patient access. The process involved the practice completing a self-assessment on topics related to access for example, capacity, appointments, patient feedback and the practice plans for monitoring and improvement. Following the completion of the assessment the GPPST would support the practice to develop an action plan. The practice management team were in the early stages of completing their assessment.

Source	Feedback
NHS.UK website	There were five reviews on the NHS UK website, ratings varied between, one and three stars. All of the reviews raised concerns about access. These related to: <ul style="list-style-type: none"> <li>• The length of time it takes for practice staff to answer the telephone.</li> <li>• Patients described being on hold for over an hour and attempts to contact the practice over a number of days.</li> <li>• Being told that there are no appointments and directed by reception staff to go to a walk in centre or call NHS 111.</li> </ul>
Patient experiences	Patients spoken with continued to raise concerns about access.

### 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.	13
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	5
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Example(s) of learning from complaints.

Complaint	Specific action taken
<p>Patient raised concerns about reception staff attitude when trying to make an appointment. Patient expressed that the member of staff was abrupt and unhelpful, putting them on hold without telling them.</p>	<ul style="list-style-type: none"> <li>• A senior member of staff spoke with the patient and apologised.</li> <li>• The complaint was discussed with the member of staff involved. A recording of the call was discussed and a reflection on the contents and what could have been done differently to improve the patient experience and provide learning for the staff.</li> </ul>
<p>Elderly patient received a text message from the practice to make an appointment to discuss test results. The patient tried for 2 days to make an appointment.</p>	<ul style="list-style-type: none"> <li>• Patient was called by the practice manager and offered an apology.</li> <li>• The patient had managed to book and confirm an appointment.</li> <li>• Discussions with staff advised staff on the steps to take to accommodate and reassure elderly patients.</li> </ul>

## Well-led

## Rating: Good

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership at all levels.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• We saw evidence of a clear and identified leadership structure and staff expressed a confidence in the leadership team.</li><li>• The practice management team acknowledged that there remained ongoing challenges due to the change in ownership of the practice. We found that the leadership team worked hard to develop a resilient and sustainable service for patients. This included recruiting new staff to increase capacity for appointments and therefore access for patients.</li><li>• The leaders worked with the federation and ICB to address these. This provided opportunities to develop and improve services for their practice population.</li></ul>	

### 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
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Staff were able to tell us about the vision for the development of the practice. This related to improving the services and care for the local population. Practice staff worked closely with other practices within the federation to achieve this and had developed their own business plan to monitor their progress.</li><li>• The practice had a mission statement which was accessible at the practice. Their aim was to provide better health and social care which was patient friendly and family centred.</li></ul>	

## Culture

**The practice had a culture which drove high quality sustainable care.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The management team operated an open-door policy and staff were encouraged to share ideas and raise any concerns. Staff told us that they felt able to raise any formal concerns.</li> <li>• The practice had a named freedom to speak up guardian and staff felt able to raise concerns.</li> <li>• The practice had whistleblowing and duty of candour policies.</li> <li>• Staff we spoke with were positive about the culture of the practice. They found leaders supportive of their wellbeing and they operated zero tolerance of aggression towards staff.</li> <li>• A sample of staff records showed that all staff had received and were up to date with Equality and Diversity training as part of the practice's mandatory training requirements.</li> </ul>	

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

Source	Feedback
Staff Feedback	<ul style="list-style-type: none"> <li>• Staff told us that the practice team was supportive and there was a culture of openness and honesty.</li> <li>• Staff told us they were included in any changes that were intended to support improvement of the practice.</li> </ul>

## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
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> <ul style="list-style-type: none"> <li>• The practice governance arrangements were linked to the central governance structure of the owner organisation, Health and Beyond Ltd. The organisations structures, processes and systems were clearly set out to support good governance and management. These arrangements supported the development of its central functions such as recruitment and the development of operational policies and procedures where appropriate.</li> <li>• We found that structured medicine audits were completed. Our findings from our clinical searches of the management of medicines showed that there were gaps in the completeness of some of the reviews. We found that the practice audits had identified some of the omissions however, the frequency of the audits were not always timely so that immediate action could be taken.</li> <li>• Staff had access to policies and procedures that were regularly updated.</li> <li>• There were comprehensive meeting structures in place that were inclusive of all staff and ensured important information was shared throughout the practice team.</li> <li>• Minutes of meetings were available for those who were unable to attend the meetings.</li> </ul>	



### Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Risk assessments and arrangements were in place for managing the premises and staff.</li> <li>• Staff had received appropriate training to help manage potential risks to patients and the service, such as basic life support and fire safety training.</li> <li>• The practice was able to share with us examples of audits undertaken to support service improvements. Some of the audits carried out were in response to NICE guidance, best practice and medicine safety alerts.</li> <li>• Our clinical system searches identified gaps in the management of patients specifically relating to medicine management and MHRA guidance.</li> <li>• Following our remote review of the clinical records the practice staff carried out an audit of their medicine monitoring processes to ensure the current systems in place were appropriate. This resulted in the update of the practice systems for the ongoing monitoring of medicines.</li> <li>• The practice had a business continuity plan to mitigate risks to patients and staff in the event of any disruption to the service.</li> </ul>	

### 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:

- The practice manager, with the support of the reception / administration staff, maintained oversight of the clinical registers for patients with long term conditions to ensure they were recalled for annual health reviews.
- Our clinical searches confirmed that the majority of patients attended their appointments.
- Data was used to monitor and improve performance. Systems were in place to enable regular clinical searches in areas such as long term conditions and medicine management to take place.
- Our remote searches of the practice clinical system identified no concerns relating to the use of data and information to support decisions specific to patient care and treatment.
- The information used to monitor performance and the delivery of quality care was accurate and useful.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.
- Records were stored electronically using secure systems and the practice had a named data protection officer.

## 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice used NHS approved software when consulting with patients remotely.</li> <li>• Staff had received training and had access to guidance when undertaking remote consultations.</li> </ul>	

**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.	Partial
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> <ul style="list-style-type: none"> <li>• The practice was part of a wider network of GP practices.</li> <li>• Staff were able to raise suggestions and give feedback through the practice meetings, on an informal basis and through appraisals.</li> <li>• Prior to the COVID pandemic the practice had an active patient participation group (PPG), the numbers of which varied at meetings. The practice manager was actively attempting to bring the group back together so that face to face meetings if patients felt comfortable could be restarted.</li> <li>• The outcome of patient survey's, which included the GP National Patient Survey were usually available on the practice website with details of the action practice staff had taken to address areas of concern. However, it was noted that the most recent survey results were not available on the practice website. Information on the website states that it is currently being updated.</li> <li>• The provider worked with stakeholders and GP practices within their Primary Care Network (PCN). This allowed for sharing and learning to promote improvement in patient care.</li> </ul>	

**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> <ul style="list-style-type: none"> <li>• Practice staff were encouraged and supported to develop their skills to maintain competences and professional development. For example, the pharmacist was supported to complete the clinical pharmacist training course.</li> <li>• Practice staff were aware of the challenging demographics of the practice population and to manage this they had developed systems for recalling and supporting patients. For example, we saw there was low uptake rates for cervical cancer screening. Practice staff with the support of the Integrated Care Board and Primary Care Network (PCN) had put systems in place to increase uptake.</li> </ul>	

- We found that the practice had reviewed its systems and ensured clear protocols were in place for prioritising and ensuring patients that needed to be seen face to face would be. The practice had carried out audits of its appointment system. The audits looked at the number of appointments available, type, attendance and the number of patients who failed to attend. The outcome of the audits was used to support and improve patient access to the practice.

- We found that arrangements were in place to support learning and improvement through clinical incidents, clinical updates and audits, and clinical supervision.
- For example, ongoing audits showed that clinical staff reviewed their systems for filing blood test results, which included those that were not immediately shared by secondary care services. A monitoring process was implemented for a designated medicine management team to review blood test results monthly.
- Where changes were made as a result of the outcome of audits these were shared and discussed with practice staff as a process of learning. The practice also intended that any changes would provide staff with a clear pathway to follow and also escalate appropriately if required.

### Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices. Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

#### **Glossary of terms used in the data:**

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **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.