

Care Quality Commission

Inspection Evidence Table

Grove Medical Centre (1-545552717)

Inspection date: **24 June 2022**

Date of data download: 11 May 2022

**Overall rating: Good
Safe**

Rating: Good

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	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: <ul style="list-style-type: none"> The practice had safeguarding leads for both adults and children and policies in place to support staff in the event of a safeguarding concern. Staff we spoke with knew what to do if they had any concerns about a patient. The practice held safeguarding registers and discussed their most vulnerable patients at regular safeguarding meetings. Patient records we reviewed showed that they had been appropriately coded where safeguarding concerns had been identified. Clinical system alerts were used to identify patients who were at risk of harm or abuse. The system also identified other close contacts so that staff were aware of other family members who could potentially be at risk. Training records showed most staff were trained to an appropriate level in child and adult safeguarding for their role. Training records seen for non-clinical staff showed that not all staff had completed the training at level 2 as recommended in the intercollegiate document on safeguarding training guidance. However, staff we spoke with, which includes non-clinical staff were aware of processes that they needed to follow. Chaperoning was usually undertaken by the nursing staff and healthcare assistants. Occasionally non-clinical staff were asked to chaperone. Records we examined showed that all staff who undertook chaperoning duties had received training and been DBS checked. 	

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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Following the mergers the partners put a dedicated centralised Human Resources (HR) team in place to develop and implement their HR processes and procedures. We reviewed the recruitment files for five members of staff (both clinical and non-clinical) at each of the five practice sites we visited. However, we noted that there were gaps in the standard and completeness of documentation and information held across all practice sites. We saw that work was in progress to ensure information held was appropriate, in place for all staff and up to date. Staff told us that they were auditing the files to ensure information held was accurate and the HR team would be following up any gaps. The practice requested and checked the vaccination status of staff as part of the recruitment process. We saw that the immunisation status of all staff, specifically non-clinical staff were not available to demonstrate any immunisation that was incomplete. 	

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: Dates varied across the eight practice sites.	
There was a fire procedure.	Yes
Date of fire risk assessment: Varied across the eight practice sites.	Yes
Actions from fire risk assessment were identified and completed.	
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• There was a Health and Safety Policy in place for the whole organisation and individual risk assessments across the eight practice sites had been carried out. The Health and safety of the premises was managed by a central team.• The provider had undertaken a comprehensive Health and Safety Compliance Audit to check that Health and Safety systems and processes were in place and in safe working order at all practice sites.• Staff were alert to undertaking premises and safety checks daily. This formed part of a formal health and safety weekly walkabout. The outcome of the health and safety audits were escalated to the central team. Any issues were assessed for priority of action through a risk assessment process and reported to the partnership board. Urgent concerns identified as requiring immediate action were acted on immediately.• Records seen showed regular servicing and safety reports for electrical installations, gas safety, alarm systems and water sample checks for legionella.• Records available showed up to date servicing of fire equipment, weekly alarm checks and evidence that fire drills had been carried out.• Individual fire risk assessments had been completed at all practice sites. The provider had identified that at some practice sites the fire system had to be completely changed and updated to meet current fire prevention regulatory requirements. We saw that this work had been completed as a priority. The individual sites had notices indicating where fire assembly points were and details of regular fire alarm checks and fire drills.• Fire wardens had been identified and trained to undertake the role.	

- Training records showed fire safety training had been completed by all staff.
- Control of Substances Hazardous to Health (COSHH) risk assessments and safety information was in place.
- Calibration checks for clinical equipment and electrical safety testing for portable appliances had been undertaken at each practice site to ensure equipment was safe and in good working order.
- Formal health and safety and fire risk assessments had been completed at all eight practice sites. We found the dates they were completed varied across the different sites and were all up to date.

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. Date of last infection prevention and control audit: Varied dates across eight practice sites	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was an infection prevention and control lead for the service. • Training records seen showed that staff had completed infection prevention and control (IPC) training. • IPC audits had been undertaken across all the eight sites. Cleaning check sheets were completed for each room. • Cleaning at each site was undertaken by external contractors. We saw cleaning schedules were available at each practice site and signed by cleaning staff. • During our site visits to five of the eight practice sites we found the premises visually clean and tidy and that staff had access to appropriate personal protective equipment (PPE). • We saw records which demonstrated there were appropriate arrangements for the removal of clinical waste. • Staff we spoke with told us about the systems and processes in place to ensure clinical specimens were handled safely. 	

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">• The provider was aware of the shortage of staff particularly in the roles of reception and administration and were actively in the process of recruiting additional staff to help improve the working environment for staff and increase access to services for patients.• Staff worked flexibly and had opportunities for overtime to cover absences.• The provider used a rota system for managing the allocation of staff. This was centrally managed and included guidance relating to for example, GP leave so that the rota manager could ensure there was always sufficient doctors available.• The practice had a locum pack to support staff working at the practice on a temporary basis. This included information about the IT systems, health and safety and relevant contact numbers.• Emergency equipment and medicines were held at each of the practice sites. We found that at one practice site there was a lack consistency for the oversight of emergency equipment and medicines to ensure ease of accessibility, availability and checking took place. One of the possible reasons for this was the absence of a regular practice nurse to provide consistency and oversight in these areas at the practice. The provider addressed the storage and accessibility of the equipment and medicines immediately. Evidence which included photographs and an updated standard operating procedure was shared with us to confirm this. This action also led to a review of the management and storage of emergency medicines and equipment across all the practice sites. Risk assessments were completed on what emergency medicines would be held across the practice sites with some standardisation where appropriate.• Training records showed that staff were up to date with their basic life support training.• Reception and administration staff who handled calls to the practice and arranged appointments with the clinical team were aware of potential red flag symptoms. Staff knew to notify a GP or other clinician such as advanced nurse practitioners, paramedics and clinical pharmacists of concerns.	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Our clinical searches found that clinical records were well maintained and test results were managed appropriately and in a timely manner. • The practice was aware of issues with the coding of patient records and were actively taking action to manage the backlog created by the mergers and impact of the COVID pandemic. • The provider had identified systems for managing information coming into the practice. Staff were allocated workflow tasks and the aim was for staff to complete this work during their shift. Staff were aware of the process to follow to manage any workflow that could not be completed. These would be tasked to their colleagues. The GPs and reception supervisors had oversight of this work to ensure appropriate levels of competence was maintained. 	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.71	0.81	0.79	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). (01/04/2021 to 31/03/2022) (NHSBSA)	6.2%	6.2%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets	5.57	5.21	5.29	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	102.5‰	138.1‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.64	0.66	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	7.5‰	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.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England 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

Medicines management	Y/N/Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> National prescribing data showed that the practice prescribing was in line with other practices locally and nationally. The practice regularly reviewed its prescribing practice as a clinical team with the support of the practice pharmacists' medicines management team. Non-medical prescribers were allocated a clinical supervisor. We saw evidence that individual audits and supervision of the prescribing practices and clinical reviews of non-medical prescribers were carried out to ensure competency standards were maintained. At this inspection we found that the systems for the safe management of medicines had been reviewed. Our clinical searches showed that most patients had received appropriate medicine reviews. 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. We identified 147 patients prescribed three different DMARDs of these nine patients (6%) had not had the required monitoring. We looked at the records of four patients identified as being overdue monitoring. All patients were receiving shared care with the local hospital. Our interview with the GPs identified they were aware of this and had taken appropriate action to follow up the patients. The outcome of blood tests carried out at the hospital were followed up, adjustments made to patient's medicines, referrals made to the hospital where needed and alerts put on patient records. Our review identified the number of patients prescribed high-risk medicines. One of the medicines we reviewed was Lithium, a medicine used to treat patients with a mood disorder. Our search showed that 20 patients were prescribed Lithium and of these 12 patients had not had the required monitoring. We reviewed five of the 12 patient records, four showed that monitoring was due and planned for. The remaining patient record showed that the information needed to update the records had been requested from the hospital. We saw that all patients received shared care with a local hospital. Other medicines we reviewed related to medicine safety alerts were those used in combination with other medicines to treat high blood pressure (hypertension) and heart failure. Records showed that 34 patients had been prescribed this medicine. A random review of five patient records showed four patients prescribed these medicines had not had the required monitoring before issuing a repeat prescription and one patient was no longer prescribed a combination of these medicines. Records showed that although not carried out, monitoring had been requested prior to issuing a repeat prescription and these patients were being followed up. Two patients received shared care and most of their follow up, care and treatment took place at the hospital. There was no indication that these patients had been informed of the risks. The remaining two patients who were treated by the practice had been made aware of the risks and alerts added to their records confirmed this. The practice had taken action to follow up these patients. Where recommended emergency medicines were not routinely held, the practice had undertaken appropriate risk assessments. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> 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:	26
Number of events that required action:	26
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There were systems in place for reporting and managing incidents and significant events. Staff we spoke with were aware of the processes in place and told us that learning was shared at practice learning events and through regular weekly communications with the senior team. We saw minutes from meetings where learning from incidents and events were discussed. 	

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

Event	Specific action taken
Practice staff found that a clinical letter was incorrectly filed.	The practice staff investigated the error and identified that the current staff shortage of reception staff was one of the causes that had contributed to the error. The reduced number of staff meant an increased workload for staff to manage. The practice was actively trying to recruit staff. Policies and procedures for filing were reviewed and staff received additional training in the process they should be following.
Cold chain breach	Nursing staff had not been informed that there were plans to disconnect the electricity at some point over the weekend. This meant that the fridge was switched off at this time. This resulted in the destruction of vaccines due to the risk of instability and the effective of the vaccines. An investigation showed that the cause was due to the lack of communication. The incident and its outcome was shared with all staff. The importance of ensuring all staff are made aware of any future works at the practice, specifically any that may affect the day to day running of the practices was stressed to all staff. This included the team of staff responsible for planning and confirming any work to be carried out.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Medicine safety alerts were managed by the organisation pharmacy team. • We saw examples where relevant safety alerts were shared with staff and a tracking system used to ensure they had been read and acknowledged. • The practice ran regular audits to ensure actions taken against medicine safety alerts such as those from the Medicines and Healthcare products Regulatory Agency (MHRA) were maintained. Our clinical searches confirmed these checks were in place. • We looked at five records of patients taking a combination of medicines, where one of the medicines could reduce the effect of the other. Records showed ongoing work was being carried out to ensure appropriate discussion and follow up had been undertaken. 	

Effective

Rating: Good

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Clinical staff told us that they accessed training and updates relevant to their roles to keep them up to date. They could access clinical guidance through the National Institute for Health and Care Excellence (NICE). In line with guidance during the pandemic the provider had focused on their high-risk patients. They had developed a recovery plan to help safely manage their patients with long term conditions and additional needs. Our clinical system reviews found appropriate follow up, care and treatment was provided in the management of patients with or at risk of long-term conditions. For example: <ul style="list-style-type: none"> Our clinical searches included a review of patients with the potential of a missed diagnosis of diabetes based on blood test results. We looked at the records for five patients and found three patients were being appropriately monitored, one patient had been given an appointment and the remaining patient had not been coded, which could result in potential harm if not followed up. The nurse practitioner diabetic lead and their team were actively following up patients diagnosed with diabetes. We reviewed records for five patients with diabetic retinopathy (a complication of diabetes). Four patients were up to date with a follow up and monitoring. The remaining patient was due their review and an appointment had been booked. 	

- The records of five patients with asthma prescribed high numbers of short acting inhalers (which may indicate poor asthma control) were reviewed. All but one had been followed up for an asthma review in the last year. The provider had identified this and was in the process of updating patient records as part of their plans to manage backlogs in coding. Records showed that appropriate safety measures were in place should the patient have an acute asthma episode.
- We reviewed records for five patients with later stage Chronic Kidney Disease and found the blood tests for one patient were overdue. The records of another patient showed that the practice was having trouble locating the patient at the address provided. We saw that the practice was actively trying to locate the patient.
- We randomly reviewed the records of five patients with hypothyroidism. The records showed that the practice clinical staff had identified that the monitoring of these patients were overdue. Although this was the case, patients were not considered at risk as their last test results were within a safe range. We also found that the patients had been actively recalled by the practice to attend an appointment.
- The patient records we reviewed showed evidence of shared care with hospitals and community clinics was provided for patients with long term conditions.
- The clinical staff demonstrated that potential coding issues in relation to diabetes and other long term conditions were being addressed and patient records updated. The provider was aware of the backlog in coding of patient records and the problems this presented. A risk assessment had been carried out to identify the extent of the problem and the provider had rated this as a high priority. A plan of action included identifying and training a team of staff to address this. The provider planned to recruit and train additional staff.

Effective care for the practice population

Findings

- The practice had the support of a healthy aging co-ordinator through the primary care network (PCN). The coordinator worked closely with a care co-ordination team, social prescriber and health coach.
- Health checks, including frailty assessments, were offered to patients over 75 years of age. Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- Patients who were unfit to travel, housebound and those living in care homes were supported by a dedicated home visiting team of staff. The team included pharmacists, paramedics, and advanced nurse practitioners.
- 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

- Our review of clinical records found appropriate recall and follow up was in place for patients with long term conditions.
- The provider had identified teams of clinical professionals to lead on the management of patients with long term conditions across the organisation. For example, one of the advanced nurse practitioners was the lead for patients diagnosed with diabetes. The lead nurse had identified 3971 patients across all the providers practice sites and 3134 of these patients were registered at Grove Medical Centre. The practice had also recommenced working with the Royal Wolverhampton NHS Trust on the project 'Working with Insulin, Carbohydrates, Ketones and Exercise' to manage patients with diabetes (WICKED). A diabetic risk stratification tool was used to assess and prioritise care management decisions.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the clinicians worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Clinical staff followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. Patients with asthma had an asthma management plan in place.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	325	387	84.0%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	319	406	78.6%	Below 80% uptake
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)	319	406	78.6%	Below 80% uptake
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)	318	406	78.3%	Below 80% uptake
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)	376	465	80.9%	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

- The practice was not meeting the WHO based target of 95% uptake for childhood immunisations for all age groups. This is the recommended standard for achieving herd immunity. The practice was also not meeting the 90% minimum uptake target for childhood immunisations in all age groups.
- Verified data showed that the uptake of children aged one who had completed a primary course of immunisation was 84%. The uptake of children aged 5 who had received immunisation for measles, mumps and rubella was 80.9%. The uptake of immunisations for children aged two was below 80% in all three immunisation categories as shown in the table above.
- Staff told us about the action they were taking to improve the uptake of childhood immunisations. The practice nursing teams who administered childhood vaccines worked closely together to educate parents and guardians on the importance of the immunisation programme. The team worked with reception and administration staff on the call and recall system for children not brought to appointments. Any parents/guardians that failed to bring children to an appointment were contacted at the time and rebooked. Children were also discussed with the health visitor and at multidisciplinary team (MDT) meetings.

- Verified data we examined showed that there had been a decline in the uptake of childhood immunisations since the COVID pandemic period. Prior to this the practice had achieved either the WHO target of 95% or above the minimum target of 90% over a four year period for children aged one and two.

Cancer Indicators	Practice	CCG 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: 31/12/2021) (UK Health and Security Agency)	63.1%	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)	38.4%	55.7%	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)	55.0%	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)	44.2%	50.3%	55.4%	No statistical variation

Any additional evidence or comments

- The uptake of cervical screening was below the 70% uptake and the England average of 80%. The data showed that there had been a rapid decline in uptake since the start of the pandemic.
- The practice told us that they had been proactively contacting patients that were overdue cervical cancer screening by phone or letters. Practice nurses told us that they would take time to speak to patients who were nervous about attending to provide reassurance. Opportunistic cervical screening was offered when patients attended for other appointments. Patients were able to attend the extended access hub for cervical cancer screening in the evenings or at weekends.
- The uptake of other national cancer screening programmes, which included breast cancer and bowel cancer screening was below the local and England averages. Active education was provided to patients to encourage and stress the importance of attending these screening procedures.

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 partnership shared with us various quality improvement activities that they had been involved in, this included:</p> <ul style="list-style-type: none">• The provider had a clinical audit programme in place. A review of the findings and actions to be taken was overseen and supported by the clinical leadership group.• The pharmacy team had set up routine audits run to help support the safe management of medicines.• Audits were carried out to monitor and review medicine prescribing at the practice in response to safety alert notifications. The practice participated in local antibiotic prescribing audits and were able to show improvements in prescribing.• One of the audits carried out over the past two years looked at the practice compliance with MHRA guidance relating to the prescribing of EpiPens, an injectable medicine used for the emergency treatment of life-threatening allergic reactions.<ul style="list-style-type: none">○ The first cycle of the audit was carried out in December 2020. The practice set out to review and improve prescribing practices for patients prescribed EpiPens. The audit looked at all patients prescribed EpiPen auto-injectors in the last 18 months to ensure they had been issued with a prescription for two EpiPens. The search identified 50 patients had been prescribed EpiPens, of those eight patients (16%) were prescribed only one pen in the previous year. The aim for the practice was that 100% of patients would have two EpiPens prescribed. The audit showed that the practice had achieved 84%. Action was taken by the practice staff to address this through a review of their policies for any new prescriptions issued and existing patients were prescribed a second EpiPen.○ A re-audit was carried out in October 2021. The search found that 51 patients had been prescribed an EpiPen, an increase of one patient on the previous year and of these nine had been issued with only one EpiPen. The practice also noted that two patients needed further follow up to review decisions made. The results showed that there had been minimal change since the first audit. Possible reasons for this were identified as patients not aware that they should always have two EpiPens so that if an EpiPen was used or had expired they always had another one available. To address these issues an alert was linked to the records of patients prescribed an EpiPen. Patients were made aware of the need to always have two EpiPens and informed of the importance of requesting a further prescription when one EpiPen is used or expires. The outcome of the audit was also shared with the clinical staff teams.○ A third audit cycle was completed in May 2022. A re-audit of patients prescribed only one EpiPen showed improvement and had reduced to three patients from the nine identified at the last audit. The practice planned to repeat the audit at the end of this year

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff had access to and completed training identified as mandatory by the provider. • Staff with new and extended roles had a designated supervisor who undertook annual audits of their clinical work to ensure their competence. • Clinical staff had opportunities to attend local networks and online events to help maintain skills and development. • Training records seen demonstrated that staff in extended roles had received appropriate role specific training for the work they performed. • We saw from staff records that a three month induction process was in place. However, the contents and completion of the documents we reviewed did not include sufficient and appropriate information to clearly demonstrate staff competency. For example, there was an absence of information on the topics covered, discussions held, outcomes and feedback to support decisions made when extending the induction period, offering a permanent position or reason for unsuitability. The provider, specifically the lead for human resources and their team took immediate action to address this. The provider shared updated copies of the induction and competence documents, which they had reviewed, redesigned for clarity on how to complete and implemented. • Staff had received appraisals. Information from the outcome of appraisals was used to support the restructuring process where staff had expressed a wish to undertake new roles. In some cases, staff had been promoted into new roles. The restructuring process had introduced a new internal career progression organisation structure. The changes also offered staff the opportunity to take up new roles. 	

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: <ul style="list-style-type: none"> The practice was developing a multidisciplinary workforce that could best meet the needs of patients. We spoke with staff from across the organisation, including clinical pharmacists, advanced nurse practitioners, practice nurses, musculoskeletal physiotherapists, and health care assistants. All the staff understood how they fitted in within the organisation when supporting patients. The practice held regular multi-disciplinary team meetings with community health care staff and community teams to discuss the care and support needs of all patients. 	

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: <ul style="list-style-type: none"> The partnership was part of a wider primary care network and was developing a diverse workforce of clinical support professionals, health and wellbeing staff team 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. One of the developments within the organisation was the implementation of a team of nursing staff to lead on the management and support of patients with diabetes or at risk of diabetes. Staff we spoke with were aware of services they could refer and signpost patients to, which could support them to live healthier lives. For example, wellbeing and exercise, counselling and substance misuse support services. The organisation was involved in two National Health Service England (NHSE) inequalities and improvement programme projects. The programme involved integrated working between primary and secondary care. The aim was to educate and include patients in their care and treatment. The two projects the practice was involved with related to the management of patients diagnosed with chronic kidney disease (CKD) and diabetes. 	

- Health and Beyond Ltd. had employed health and wellbeing professionals to develop a local Wellbeing hub at one of the APMS practices to provide health checks and lifestyle support to patients across the organisation.
- Work was underway through the newly appointed patient engagement lead to raise patient awareness of the new team roles and work alongside the health lifestyle team to promote patient wellbeing.

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 Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Training records showed that clinical staff completed training relating to the Mental Capacity Act and Deprivation of Liberty Safeguards. • Staff we spoke with had an understanding of relevant legislations and guidance when obtaining consent and decision making and had access to policies and procedures to support them. • Our clinical searches identified that DNACPR decisions made were appropriate and clearly recorded. 	

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 people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We spoke with PPG member both via an online team call and in person. Overall, the members were positive about the practice and the services they received. Patients told us that they had initial concerns when the practices first merged and a new organisation took over however, now felt that things were improving. We found that some patients had concerns about staff attitude. The practice was aware of the concerns raised by patients and had attributed some of the frustrations to staff shortages due to vacancies and absences. Staff had undertaken training in customer care and conflict resolution to help improve the patient experience. The practice employed a patient engagement lead to help improve communication with patients. There was a formal agenda of planned activity to encourage patient engagement for example, updating noticeboards, updating the practice website and actively working with the Patient Participation Group (PPG) to listen and address concerns raised by patients. 	

Patient feedback	
Source	Feedback
NHS UK	There were 24 reviews posted in total across all eight practice sites over the last 12 months on the NHS website. There were comments made about six of the eight practice sites. Most of the comments were negative about access to the practices, delays in answering the telephone and staff attitude. However, there were some positive comments which described staff as helpful, compassionate and professional.
Google Reviews	There were separate reviews and ratings for each of the practices. The ratings scores ranged between 1.5 and 3.9 out of 5 stars based on 143 reviews, posted in the last 12 months. Most comments made were negative and include concerns about access, delays in answering the phone, not being able to see a GP, no specific or indication of a time to expect a telephone consultation call, poor communication and a delay in getting test results. However, there were some positive reviews about patient experience of the service. Positive staff groups, very good and helpful.
Patient Experience	We received feedback from patients representing each of the practices, they were positive about the service received and found the staff polite and respectful. They felt the practice was receptive to feedback from patients and were making improvements and addressing their concerns.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	89.7%	86.3%	89.4%	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 (01/01/2021 to 31/03/2021)	87.8%	85.0%	88.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	92.7%	93.8%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	70.6%	76.8%	83.0%	Tending towards variation (negative)

Any additional evidence or comments

- Results from the latest GP national patient survey published in July 2021 were mostly in line with other practices locally and nationally in the responses received to questions relating to patient experience.
- The practice had identified lower scores for the question relating to patient's overall experience of their GP practice. The changes to the operation of the practice due to the mergers, staffing problems and changes to the workforce structure to address this had an effect on continuity of care for patients.
- The practice had reviewed its national patient survey results. The review looked at where patients had scored their experience as positive and where improvements were needed. The practice planned to undertake a short survey, using the national patient survey questions, which focused on the patient experience related to caring.
- The practice used the outcome of all surveys carried out, and other sources of feedback for example, patient participation group (PPG) meetings to develop an action plan to improve the patient experience.

Question	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: Staff we spoke with gave us examples as to how they supported patients to understand their care for example, through the use of health education, translation services and working with a patient's carer.	

Source	Feedback
Interviews with patients/PPG.	Patient representatives we spoke with told us how positive attempts had been made to improve communications between the practice and patients. Members of the PPG were aware of the patient engagement lead employed to improve communications and support preventative health education for patients. The lead would also help patients to understand how they could get support and the services available to them.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	84.3%	90.3%	92.9%	Variation (negative)

Any additional evidence or comments

<ul style="list-style-type: none"> Results from the GP National patient survey had identified lower scores than the local and national averages for the question relating to their involvement in decisions about their care and treatment. The practice was aware of this and was proactive in making changes to improve the staffing structure, training and active recruitment. For example, forming teams of staff who would be responsible for the care of patients with specific long term conditions.
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	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

Carers	Narrative
Percentage and number of carers identified.	At the time of the inspection the practice provided a service to a population of 38,383 patients. There were 1168 patients registered as carers at the practice. This represented approximately 3% of the practice population. This was over the suggested minimum of 2%. 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"> • Carers were offered an annual health check. • Carers were offered an annual flu vaccine. • The practice made every effort to identify young carers. • The practice staff called all the carers on the register during the peak of the pandemic to check on their wellbeing.
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> • The practice maintained a register of patients who received end of life care. • Families who had a bereavement were contacted and offered an open invitation to attend the practice, if they wanted to advise or to discuss anything further. • The practice had bereavement packs which included information and details of support services available for the family.

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: <ul style="list-style-type: none"> • Staff recognised the importance of and took measures to ensure people's dignity and respect when using the service. • 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. • Confidentiality was covered as part of new staff induction and staff signed a confidentiality agreement as part of their employment. 	

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none">• Grove Medical Centre was a merger of eight practice sites between 2019 and 2021. Following the mergers the partnership had been working to develop a sustainable service for the local population.• Health and Beyond, the parent organisation had inherited a range of premises including new purpose-built practices and converted houses. All were fully adapted for the provision of general medical services.• The partnership had received some negative feedback in relation to access following the merger and during the pandemic were working to address this through changes to for example, skill mix and increasing staffing numbers especially into the roles of receptionists and administration. Some reception staff had been trained as Care Navigators to help direct patients to the most appropriate clinician for support.• Patients had complained that they had struggled to access services through the telephone lines. The practice had set up specialist teams of staff with advanced clinical qualifications to provide care and treatment to patients with long term conditions. The teams of staff were proactive in calling their specific group of patients to arrange appointments for condition reviews and medicine reviews to reduce the need for patients to contact the practice. The practice was aware that there was a shortage of reception and administration staff and were in the process of recruiting additional staff.• Extended access appointments were available in the evenings and at the weekends to provide a wider range of additional appointments at one of the organisations Alternative Primary Medical Services (APMS) practice sites. APMS contracts allows providers to contract with non-NHS bodies to supply enhanced and additional primary medical services.	

Practice Opening Times

Day	Time
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	8.30am – 6pm
Tuesday	8.30am – 6pm
Wednesday	8.30am – 6pm
Thursday	8.30am – 6pm
Friday	8.30am – 6pm

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.
- There was a medicines delivery service for housebound patients.
- 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 offered extended hours through its local Hub arrangements where patients were able to access appointments outside of normal working hours seven days a week. Out of Hours (OOH) arrangements was with NHS 111.
- 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.

Access to the service

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

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	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	Yes
There were systems in place to support patients who face communication barriers to access treatment	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">• Patients had access to an initial assessment, test results, diagnosis and treatment.• Information we received from patients told us that they were not always able to be seen in a timely manner to meet their needs. The reasons they gave for this was due to not being able to access the practice for an appointment and it was difficult to get through to the practice by telephone. Plans to manage and improve the patient experience was part of the practice post covid recovery plans.• The GPs offered home visits for patients who were housebound (the frail, elderly or vulnerable patients). Patients or their carer were asked to contact the practice. A detailed process was in place for making informed decisions on undertaking home visits. Decisions on whether a home visit was needed was made by the GP.• The practice offered a variety of clinics, which included, asthma and diabetes.	

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	43.4%	N/A	67.6%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	53.9%	62.7%	70.6%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	48.5%	62.2%	67.0%	Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	68.9%	76.3%	81.7%	Tending towards variation (negative)

Any additional evidence or comments

- Results from the latest GP national patient survey published in July 2021 found low scores compared to local and national averages for questions about access.
- We found the practice had undertaken some work to try and improve access and had worked to develop an action plan. Monitoring to demonstrate whether the action plan was having a positive impact and improving access for patients was not available.

Source	Feedback
NHS UK	There were 24 reviews posted in total across all eight practice sites over the last 12 months on the NHS website. Most of the comments were negative and highlighted concerns about access to the practices. However, some of the comments suggested that some improvements had been made.

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.	35
Number of complaints we examined.	6
Number of complaints we examined that were satisfactorily handled in a timely way.	6
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Information about how to make a complaint or raise concerns was available to patients. The practice informed patients of any further action that may be available to them should they not be satisfied with the response to their complaint. The practice had a complaint policy and procedures in place which were available and easily accessible to staff. Complaints were discussed at the practice meetings and any trends and learning identified. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient experienced a lack of access to appointments and a delay in answering the telephone.	The practice sent a letter of acknowledgement to the patient. An investigation was carried out, changes were implemented and learning shared with staff. Changes made included instructing staff to not tell patients to call back at 8am but to always offer the next available appointment. Staff were also instructed to utilise the appointments at one of the practices used to treat patients with minor illnesses.
Delay in receiving medication	The practice sent a letter of acknowledgement to the patient. An investigation was carried out and the systems in place for issuing prescriptions through pharmacies were reviewed. Learning was shared with staff. The importance of following the process and working in partnership with the local pharmacies to avoid delays in requesting, authorising and dispensing patients' medicines.

Well-led

Rating: Requires Improvement

The practice was rated as requires improvement for providing well led services because at this inspection we found that:

- Leadership arrangements did not consistently demonstrate an open culture in which staff felt engaged and enabled to raise concerns.
- The continued negative feedback from patients about access did not demonstrate effective management oversight of the impact if any of the action taken by the provider to address the concerns.

Leadership capacity and capability

Leaders had the skills to deliver high quality care. However, staff concerns highlights issues about capacity and the visibility of leaders, which could impact their ability to consistently provide 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.	Partial
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Grove Medical Centre was formed in 2019 following the merger of eight GP practices. The partnership is part of a limited company of practices collectively known as Health and Beyond Ltd. Since merging, the partnership and the parent company Health and Beyond Ltd. had developed a strong centralised clinical and managerial leadership team, that had been working hard to develop a resilient and sustainable service.• The organisation told us that it had faced a challenging time, shortly after the merger, in addition to the pandemic there were complaints from patients around access. The overarching organisation, Health and Beyond Ltd. spoke about the challenges of the COVID-19 pandemic and how they had adapted their practices in order to continue to deliver services to their population.• We saw evidence of an identified leadership structure. However, anonymous whistleblowing concerns received by the care quality commission (CQC) prior to the inspection suggested that not all staff had confidence in the leadership team and plans for how the practices would operate following the mergers. Concerns raised for example, included staff capacity, movement of staff and poor communication.• The provider had been made aware of the initial concerns received by CQC, which they were asked to investigate. However, despite the continued efforts by Health and Beyond Ltd. to make improvements, CQC continued to receive whistle blowing concerns. Further anonymous concerns were received at the time of this inspection. A decision was made to extend the inspection so that further evidence could be gathered and the issues raised explored further. This involved giving all staff the opportunity for their voice to be heard and or complete a questionnaire and return it directly to the CQC.	

Vision and strategy

The practice had a 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.	Partial
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"> Health and Beyond had a mission statement which was accessible on its website. Their aim was to provide better health and social care which was patient friendly and family centred. The vision across all practices was to develop a partnership between patients and their clinicians that allowed them to work with patients to deliver high quality health and social care services and meet the needs of their registered population in Wolverhampton. Some of the staff we spoke with were aware of the practice's vision and values and told us that this was discussed at a staff presentation event held following an external review of staff and patient views. However, staff told us that they had not been involved in the development of the practice vision, values and strategy. The provider had developed plans for recovery from the pandemic, managing sustainability and improving patient satisfaction. The plan aimed to transform the way services were delivered in line with the health and social care needs and access for their patient population groups. The strategy also included supporting the health and wellbeing of staff. 	

Culture

The practice culture did not effectively support 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.	Partial
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.	Partial
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff we spoke with from across the organisation were not all positive about the way in which the organisations had merged and felt they were not working in a supportive working environment. The whistle blowing concerns we received expressed concerns about communication, lack of staff and management style. Staff also felt that they would not feel comfortable with raising any issues. Due to the rapid changes, re-organisation and working across sites staff found that there were difficulties in working as a cohesive team. This was further impacted by the pandemic. The provider was aware that there was concerns amongst staff and had developed plans to address these as part of the restoration and recovery strategy. The organisation planned to 	

introduce a staff wellbeing forum and regular staff briefings to share information with staff and celebrate success. The provider hoped that the briefings would be a way of conveying thanks to staff for their continued support, a way to keep staff updated about planned developments across the organisation and to provide staff with the opportunity to ask questions.

- The provider had provided staff with access to a nominated Freedom to Speak Up Guardian to help staff to feel safe to voice any concerns and develop effective engagement and communication with the leadership team.
- The practice had whistleblowing and duty of candour policies.

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

Source	Feedback
Staff questionnaires	<p>To help us review and explore the issues highlighted in the anonymous whistleblowing concerns we received a questionnaire was sent to all staff across the organisation. Twenty four questionnaires were returned. The overall feedback identified several areas of concern. These included:</p> <ul style="list-style-type: none"> • Communication • Pay • Staffing levels / Staff skill mix and training • Workload <p>Areas where staff highlighted most satisfaction included:</p> <ul style="list-style-type: none"> • Their roles and the work they do • The new structure allowed for progression / career development plan • Friendly supportive team

Governance arrangements

Governance arrangements identified staff responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The partnership had worked to build a new single organisation and new team structure following the merger of eight practices. This included a senior clinical leadership team, managerial leadership team and multi-disciplinary staffing structure. • New roles and teams had been established in developing the organisation and meeting the needs of patients. These included care navigators, workflow administrators, acute care team and medicines team. The teams worked together to deliver an improved patient experience. Staff received training and support in their new roles and those we spoke with were clear about their roles and responsibilities. • Individual partners also had lead roles that supported the new team structures and ensured the competence of staff. • The practice was led by a board of partners and governance arrangements included localised team meetings which fed into the central clinical and senior managers meetings. • Staff told us that most communication was shared via emails and WhatsApp staff groups. Regular online meetings were also held for the different staff groups. Staff felt that more face to face meetings were needed. • Policies and procedures were kept up to date and were accessible to all staff. 	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a 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"> The practice used a comprehensive health and safety checklist which was completed on the monthly walkabout of the premises. Health and Safety risk assessments had been completed and plans put in place to mitigate any risks identified. Risk assessments and arrangements were in place for managing the premises and staff. Our clinical system searches found appropriate management of patients and clinical risks. Staff had received appropriate training to help manage potential risks to patients and the service, such as basic life support and fire safety training. The practice was able to share with us examples of audits undertaken to support service improvements. New services were monitored through direct supervision and audit of new staff roles to ensure competence. The practice had a business continuity plan to mitigate risks to patients and staff in the event of any disruption to the service. 	

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

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

Explanation of any answers and additional evidence:

- During the pandemic the partnership had developed comprehensive plans as to how it would use the various practice sites to keep patients safe. The organisation used one of its practice sites to provide care for patients with minor illnesses and used. Extended hours services from 6.30pm – 8pm weekdays and at designated times at weekends. One of the practice sites was used as a vaccination centre and another practice site remained set up to enable the provider to still see patients with potential COVID-19 symptoms safely.
- Throughout the pandemic the practice had triaged patients and any patients that needed to be seen face to face were booked in.
- The practice had developed specific plans as part of their recovery following COVID-19. These detailed priorities that needed to be covered for example, medicine reviews and where it was safe to delay in line with national guidance.

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: <ul style="list-style-type: none">• We saw that the practice used information to support the call and recall of patients with long term conditions, to identify priorities during the pandemic, to support improvements with access and in the management of medicines.	

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had a support team with a lead role for ensuring technology was being used appropriately. • Security arrangements for the various systems used for video consulting and messaging patients were in place. • Phone messages informed patients where calls were recorded. • Patients signing up for online services were required to provide proof of identity. • Staff undertaking virtual consultations checked patients' identity at the start of a call. • We saw that the practice registration with the Information Commissioners Office was in date. 	

Engagement with patients, the public, staff and external partners

The practice had some systems in place to involve 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.	Yes
Staff views were reflected in the planning and delivery of services.	Partial
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">• The practice together with the existing Patient Participation (PPG) members across the GP practices were working to form a single patient participation group to represent all practices across the partnership.• We saw that partners and managers were working with the PPG and patients to try and resolve access issues. The partnership recognised the need to improve communication with the local population and had employed a patient engagement lead to help develop structures of communication.• To address staff concerns and support the inclusion and reflection of staff views in the planning and delivery of services Health and Beyond Ltd. had worked with an independent agency to review the operation of the organisation. Forums were set up to obtain feedback from staff and patients. Feedback from staff indicated that communication within the organisation was not effective. Most staff felt that they were not involved in the organisations plans to sustain and maintain high quality care. The outcome of this was the partnership developed comprehensive action plans to share the outcome of the review with staff and discuss possible actions based on staff and patient responses and suggestions. The impact of COVID-19 meant there was a delay in implementing the plans for improvement.• The practice regularly engaged and worked with key stakeholders to address challenges and the needs of the population, this included the delivery of the COVID-19 vaccination programme and responding to local and national direction in shaping primary medical services within the primary care network. At the time of this inspection the practice had administered over 100,000 COVID vaccinations across Wolverhampton from one of its branch sites designated as a vaccination centre.• The eight practices within the partnership together with two other practices in Wolverhampton formed a wider network of GP practices called Wolverhampton South East Care Collaborative PCN.	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none">• We spoke with members of the Patient Participation Group, who found the partnership to be open and honest and were receptive to the support the PPG provided. They told us that the partnership had engaged with them and were responding to concerns raised in the local area.

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">• The partnership had continued to strengthen with the development of a diverse workforce.• The partnership had struggled with access although action plans were put in place evidence was not available too demonstrate improvement through real time monitoring.• The practice had plans in place for the appropriate coding, follow up and referral of pre-diabetic patients.• The partnership had established a multidisciplinary care home team through the PCN to reduce emergency admissions.• The partnership responded quickly to the need to set up and provide a COVID-19 vaccination centre for the local population during the pandemic.• The partnership had proactively worked to provide healthcare education and support to the wider community through working with religious organisations and a local charity.• The partnership could access the local hospital dashboard. This enabled the practice to be aware of patients who had visited the Accident and Emergency department or was admitted to hospital. The practice could then track patients who needed follow up of their health conditions.	

Examples of continuous learning and improvement

<ul style="list-style-type: none">• The organisation was working with Keele University to set up a training hub within the organisation of Health and Beyond Ltd.• A further development within the organisation was the setting up of a dedicated diabetes staff team. The team included specialist nurses, health care assistants and support from the health coaching team. The team would provide all aspects of care, treatment and wellbeing management for patients with diabetes.• The provider had set up a dedicated respiratory team to manage patients with asthma and chronic obstructive pulmonary disease (COPD), lung conditions that cause difficulty in breathing. The team was led by a specialist nurse qualified to treat patients with chronic respiratory conditions and the nurse was supported by the health coaching team.• A get moving exercise referral programme had been started (10 week programme) through the local community and supported by the provider engagement lead and health coaching team. There was currently approximately 15 to 25 patients attending the programme joining either morning or afternoon sessions.• The organisation had a team of 12 pharmacists working across all the practice sites. Each Hub had an assigned non-prescribing pharmacist and junior pharmacists. Each hub had an identified prescribing pharmacist who provided support to non-prescribing pharmacist and junior pharmacists.
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Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

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