

# Care Quality Commission

## Inspection Evidence Table

### Croston Medical Centre (1-551021659)

Inspection date: 28 June 2018

Date of data download: 29 June 2018

Please note: Any Quality Outcomes Framework (QOF) data relates to 2016/17.

## Safe

### Safety systems and processes

Safeguarding	Y/N
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Policies were in place covering adult and child safeguarding.	No
Policies were updated and reviewed and accessible to all staff.	No
Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs)	Yes
Information about patients at risk was shared with other agencies in a timely way.	Yes
Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients	Yes
Disclosure and Barring Service checks were undertaken where required	Yes
<p>Explanation of any 'No' answers:</p> <p>At the time of our visit, there was no policy for safeguarding adults available to staff. During our inspection, the practice received a safeguarding adults policy from another practice and stored it on the practice shared computer drive. This policy was very brief and the contents did not follow best practice guidelines or name the practice safeguarding lead for vulnerable adults. We were told this would be remedied following our visit. Staff we spoke with evidenced good safeguarding knowledge and knew how to report concerns.</p> <p>There were alerts on the health records of children and young people at risk that informed staff. We saw that there was no regular discussion of all vulnerable children with health visitors.</p> <p>Safeguarding training details were not present for the long-term locum GP. The practice obtained these during our inspection to show that safeguarding training had been completed appropriately.</p>	

Recruitment Systems	Y/N
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Yes
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	No
Staff who require medical indemnity insurance had it in place	Yes
<p>Explanation of any answers:</p> <p>Evidence that we saw for permanent staff showed comprehensive recruitment checks were carried out, however, this did not apply to locum staff. The documents in place for the long-term locum GP lacked references and details of safeguarding training to the appropriate level and the evidence of medical indemnity insurance indicated it had expired in March 2017. The practice obtained evidence of safeguarding training and current medical indemnity insurance before the end of our inspection and told us they would seek references.</p> <p>The practice employed a practice manager from another GP practice, who worked for an average of nine hours each week. The recruitment information for this member of staff was lacking required information, for example employment references, any gaps in employment and medical declaration as to fitness to perform their role. We were told further checks would be made according to best practice and requisite legislation.</p> <p>We saw clinical staff registration was in date although there was no ongoing management oversight of this.</p>	

Safety Records	Y/N
There was a record of portable appliance testing or visual inspection by a competent person Date of last inspection/Test: 03/07/2017	Yes
There was a record of equipment calibration Date of last calibration: 22/06/2018	Yes
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	No
Fire procedure in place	Yes
Fire extinguisher checks	No
Fire drills and logs	No
Fire alarm checks	Yes
Fire training for staff	Yes
Fire marshals	No
Fire risk assessment Date of completion; 03/06/2015	Yes

Actions were identified and completed.	No
<p>Additional observations:</p> <p>There were no risk assessments in place for the chemical products stored and used in the practice (COSHH sheets). With our advice, the practice started to produce these sheets at the time of our inspection.</p> <p>There was no record of any recent fire extinguisher checks. Dates of checks on the extinguishers themselves indicated they were last checked in 2014 and there was no certificate for annual checks of these. The practice told us before the end of the inspection they had arranged for these to be checked on 06/07/2018.</p> <p>Actions identified by the fire risk assessment indicated that regular fire drills be carried out. The last recorded fire drill was 13/06/2017. All staff were part-time and most told us it had been well over a year since they had taken part in a fire drill. There were no fire marshals nominated for the practice. The practice fire safety policy had not been completed to include information specific to the practice. There were no names for designated personnel and no fire marshals nominated for the practice. The policy also made reference to stairs and other tenants in the building which were not relevant to the practice.</p>	
<b>Health and safety</b> Premises/security risk assessment? Date of last assessment: 25/06/2018	Yes
Health and safety risk assessment and actions Date of last assessment: 25/06/2018	Yes
<p>Additional comments:</p> <p>The practice had carried out original risk assessments in January 2016. There was evidence that the criteria used for these assessments were relevant to the practice at the time and most of the identified risks had been mitigated or removed. An additional column for June 2018 had been added to the assessment of the original criteria and further checks had been indicated as done including those against some risks which the previous assessment had indicated had been removed. The original identified risks had not been updated appropriately. For example, some risks related to the practice manager's office before it was reconfigured were still on the assessment.</p> <p>We saw there was no electrical safety certificate for the building and were told that this would be arranged. The practice confirmed to us that this had been arranged for 06/07/2018.</p> <p>There were certificates of "service checks" for the practice water system in relation to risks associated with the presence of legionella (legionella is a term for a particular bacterium which can contaminate water systems in buildings). These checks had been carried out in 2016 and 2017 and both recommended that a full legionella risk assessment be carried out and that water temperatures be monitored in the practice. This had not been completed.</p> <p>There was a gas safety check completed for the premises dated 12/05/2015.</p>	

<b>Infection control</b>	<b>Y/N</b>
Risk assessment and policy in place Date of last infection control audit: 26/02/2018	Yes

<p>The practice acted on any issues identified</p> <p>Detail:</p> <p>The practice infection prevention and control (IPC) policy was out of date and named a practice nurse who had left the practice in 2017 as the lead for IPC even though the policy was indicated as reviewed in June 2018. The current practice nurse told us they were the IPC lead and had conducted the last audit. The previous audit on 31/03/2016 had identified that COSHH sheets were missing and the recent audit, although using the same check sheets for assessment, had not recorded a check for these. We found that there were no COSHH sheets in place.</p>	No
The arrangements for managing waste and clinical specimens kept people safe?	Yes

### Any additional evidence

The IPC policy indicated new staff should receive formal training in IPC within four weeks of starting employment. This had not happened for the last member of staff employed on 02/04/2018. This policy also indicated that bi-monthly unannounced inspections would take place and this had not been followed; it had been over two years since the last recorded audit. The policy also indicated that cleaning service level agreements were in place and followed. There were no recorded agreements for cleaning and no audits of cleaning services. This policy was indicated as reviewed on 25/06/2018.

### Risks to patients

Question	Y/N
There was an effective approach to managing staff absences and busy periods.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans were developed in line with national guidance.	Yes
Staff knew how to respond to emergency situations.	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
In addition, there was a process in the practice for urgent clinician review of such patients.	Yes
The practice had equipment available to enable assessment of patients with presumed sepsis.	Yes
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Yes
<p>Explanation of any answers:</p> <p>Staff and a GP told us of an event that had occurred in the practice when reception staff observed a patient waiting to be seen by a GP whose condition was visibly deteriorating. Staff had alerted the GP immediately and the patient had been ultimately confirmed as having sepsis.</p>	

### Information to deliver safe care and treatment

Question	Y/N
----------	-----

Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	No
Referrals to specialist services were documented.	Yes
The practice had a documented approach to the management of test results and this was managed in a timely manner.	No
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
<p>Explanation of any answers:</p> <p>The CCG had conducted a referral triage project to assess the quality of clinicians' referrals in the CCG. As a result of this project, they had asked one GP in the practice to review some of the referrals they had made and we were shown an audit of these. We also viewed some of these referral records for patients on the practice computerised record system. We saw some referrals made by one GP lacked sufficient detail to ensure relevant information was passed to secondary care services appropriately.</p> <p>We saw patient test results were managed in a timely way, however, there was no documented policy for this. The practice told us they had written this policy following our visit.</p>	

### Appropriate and safe use of medicines

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).(01/07/2016 to 30/06/2017)(NHS Business Service Authority - NHSBSA)	0.96	1.05	0.98	Comparable to other practices
Percentage of antibiotic items prescribed that are Co-Amoxiclav, Cephalosporins or Quinolones.(01/07/2016 to 30/06/2017) (NHSBSA)	7.1%	9.7%	8.9%	Comparable to other practices

Medicines Management	Y/N
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
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Yes
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example audits for unusual prescribing, quantities, dose, formulations and strength).	Yes

There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were systems for the safe ordering, checks on receipt, storage, administration, balance checks and disposal of these medicines in line with national guidance.	N/A
Up to date local prescribing guidelines were in use.	Yes
Clinical staff were able to access a local microbiologist for advice.	Yes
For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance.	Yes
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	Yes
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Yes
There was medical oxygen on site.	Yes
The practice had a defibrillator.	Yes
Both were checked regularly and this was recorded.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Yes
<p>Explanation of any answers:</p> <p>We reviewed the health records of 10 patients who were prescribed methotrexate (a high-risk medicine requiring regular monitoring). Of those 10 patients, only three had medicine review dates set and two of those were out of date. When assessing whether monitoring tests had been carried out, we could see from test results that seven patients had been monitored appropriately. However, one patient had no record of testing since January 2018. One patient had a letter on their record from secondary care in March 2018 that requested that the practice test that patient's bloods fortnightly for six weeks, then every two months. The only record of blood monitoring was October 2017 and the last prescription had been issued in June 2018. We were unable to confirm the letter had been seen or action had been taken and we were told the patient had very poor compliance with treatment regimes. For the last patient it was recorded that testing was being done in secondary care but there was a letter from secondary care received 25 June 2018 asking for the GP to take over monitoring. There was no record the practice had seen this request or a practice monitoring system had been set up.</p>	

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

Significant events	Y/N
There was a system for recording and acting on significant events	Yes
Staff understood how to 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.	7
Number of events that required action	7

**Explanation of any answers:**

We saw seven incidents had been recorded for the practice over the last year, however, we were told of additional incidents that had not been recorded. One of these was identical to a previous incident that had occurred that year and another was a serious incident regarding an end of life medicine that had been prescribed incorrectly. A GP told us staff and GPs were too busy to record all incidents. There was evidence of discussion of incidents at practice meetings. We were told two days following our inspection that the missing repeated incident had been documented.

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

Event	Specific action taken
An urgent patient referral was delayed because of administration staff absence.	A safety net was put in place to copy the practice manager (in post at the time of the event) into all urgent referrals made by the GPs to ensure that they were made in a timely way.*
A patient x-ray results were sent to the practice branch surgery which caused delays in patient treatment.	Staff and GPs were reminded of the importance of following up any test results ordered from the branch surgery. The x-ray test request forms were stamped with the main surgery details to ensure they were returned there.
GPs were not made aware of two patient home visits that had been requested.	The process for informing GPs of home visits was reviewed and the importance of letting GPs know of all visits was impressed on staff.
* We saw this incident had been repeated some time later when there was no practice manager in post. There had been no documentation recorded for this repeated event and the significance of this had not been used to identify and share learning appropriately.	

Safety Alerts	Y/N
There was a system for recording and acting on safety alerts	Yes
Staff understand how to deal with alerts	Yes
Comments on systems in place: We saw patient safety alerts were dealt with appropriately and there was recorded discussion of alerts in clinical staff meetings.	



# Effective

## Effective needs assessment, care and treatment

Prescribing				
Indicator	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU). (01/07/2016 to 30/06/2017) (NHSBSA)	0.38	0.76	0.90	Variation (positive)

## People with long-term conditions

Diabetes Indicators				
Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	77.1%	82.5%	79.5%	Comparable to other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	7.9% (15)	12.7%	12.4%	
Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2016 to 31/03/2017) (QOF)	60.1%	79.4%	78.1%	Variation (negative)
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	8.9% (17)	9.4%	9.3%	
Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2016 to 31/03/2017) (QOF)	75.0%	79.1%	80.1%	Comparable to other practices



QOF Exceptions	Practice Exception rate (number of exceptions)		CCG Exception rate	England Exception rate	
	9.5%	(18)	14.0%	13.3%	

Other long term conditions				
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2016 to 31/03/2017) (QOF)	83.5%	79.1%	76.4%	Comparable to other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	0.8% (2)	11.5%	7.7%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	92.4%	92.8%	90.4%	Comparable to other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	4.3% (3)	13.7%	11.4%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less (01/04/2016 to 31/03/2017) (QOF)	83.6%	84.7%	83.4%	Comparable to other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	4.6% (30)	5.1%	4.0%	
Indicator	Practice	CCG average	England average	England comparison
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy. (01/04/2016 to 31/03/2017) (QOF)	81.0%	84.6%	88.4%	Comparable to other practices

QOF Exceptions	Practice Exception rate (number of exceptions)		CCG Exception rate	England Exception rate	
	12.5%	(9)	9.2%	8.2%	

## Families, children and young people

Child Immunisation				
Indicator	Numerator	Denominator	Practice %	Comparison to WHO target
Percentage of children aged 1 with completed primary course of 5:1 vaccine. (01/04/2016 to 31/03/2017) (NHS England)	31	31	100.0%	Met 95% WHO based target Significant Variation (positive)
The percentage children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2016 to 31/03/2017) (NHS England)	42	44	95.5%	Met 95% WHO based target Significant Variation (positive)
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) (01/04/2016 to 31/03/2017) (NHS England)	42	44	95.5%	Met 95% WHO based target Significant Variation (positive)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (first dose of MMR) (01/04/2016 to 31/03/2017) (NHS England)	42	44	95.5%	Met 95% WHO based target Significant Variation (positive)

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

Cancer Indicators				
Indicator	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening who were screened adequately within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64 (01/04/2016 to 31/03/2017) (Public Health England)	83.9%	75.5%	72.1%	Variation (positive)
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)	77.7%	72.0%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE)	65.1%	58.5%	54.5%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring	72.7%	77.5%	71.2%	N/A

within 6 months of the date of diagnosis. (PHE)				
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE)	46.4%	49.1%	51.6%	Comparable to other practices

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

Mental Health Indicators				
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	96.2%	94.6%	90.3%	Comparable to other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	0 (0)	17.3%	12.5%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	96.2%	96.1%	90.7%	Comparable to other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	0 (0)	16.1%	10.3%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	100.0%	87.9%	83.7%	Significant Variation (positive)
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	5.9% (2)	6.1%	6.8%	

## Monitoring care and treatment

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	548	549	539

Overall QOF exception reporting	3.9%	5.9%	5.7%
---------------------------------	------	------	------

## Coordinating care and treatment

Indicator	Y/N
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2016 to 31/03/2017) (QOF)	Yes
<p>Additional evidence:</p> <p>We were shown a clinical audit related to referrals to secondary care services that had been selected by the CCG as being of poor quality over the last year. There had been 102 referrals which had been identified by the clinical commissioning group (CCG) for one GP. The GP had conducted an audit of 14 of these referrals, however, no areas for improvement had been identified.</p>	

## Helping patients to live healthier lives

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with physical and/or mental health conditions whose notes record smoking status in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	97.2%	96.3%	95.3%	Comparable to other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	0.4% (4)	1.6%	0.8%	

## Consent to care and treatment

Description of how the practice monitors that consent is sought appropriately
The practice used standard templates to record consent on the practice computerised clinical record system. Clinical staff told us how they would seek and record consent appropriately. Staff were trained and had a good understanding of consent issues. We saw no specific monitoring to ensure this was done appropriately.

# Caring

## Kindness, respect and compassion

CQC comments cards	
Total comments cards received	33
Number of CQC comments received which were positive about the service	33
Number of comments cards received which were mixed about the service	0
Number of CQC comments received which were negative about the service	0

Examples of feedback received:

Source	Feedback
Comments cards	Patients praised the friendly, helpful nature of staff and wrote of the empathy shown to them when it was needed. Cards said it was a very caring practice and staff and GPs always listened to patients.

## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
3911	226	111	49.12%	2.8%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (01/01/2017 to 31/03/2017)	89.6%	83.0%	78.9%	Comparable to other practices
The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at listening to them (01/01/2017 to 31/03/2017)	97.2%	90.0%	88.8%	Comparable to other practices
The percentage of respondents to the GP patient survey who answered positively to question 22 "Did you have confidence and trust in the GP you saw or spoke to?" (01/01/2017 to 31/03/2017)	98.7%	96.3%	95.5%	Comparable to other practices
The percentage of respondents to the GP patient survey who stated that the last time they saw or	94.5%	88.0%	85.5%	Comparable to other practices

spoke to a GP, the GP was good or very good at treating them with care and concern (01/01/2017 to 31/03/2017)				
The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at listening to them (01/01/2017 to 31/03/2017)	97.3%	94.4%	91.4%	Comparable to other practices
The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at treating them with care and concern (01/01/2017 to 31/03/2017)	92.6%	93.4%	90.7%	Comparable to other practices

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	No

Any additional evidence
We saw the practice had a box and cards available on the front desk to collect the views of patients for the national Friends and Family Test (FFT). However, we were unable to see if patients completed these cards as the practice did not report the results.

## Involvement in decisions about care and treatment

Examples of feedback received:

Source	Feedback
Interviews with patients.	Patients we spoke with said they were always involved in making decisions. They said GPs were thorough and they felt they were listened to.

## National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at explaining tests and treatments (01/01/2017 to 31/03/2017)	91.7%	88.0%	86.4%	Comparable to other practices
The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care (01/01/2017 to 31/03/2017)	82.0%	83.4%	82.0%	Comparable to other practices

The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at explaining tests and treatments (01/01/2017 to 31/03/2017)	92.8%	93.7%	89.9%	Comparable to other practices
The percentage of respondents to the GP patient survey who stated that the last time they saw or spoke to a nurse, the nurse was good or very good at involving them in decisions about their care (01/01/2017 to 31/03/2017)	93.2%	89.8%	85.4%	Comparable to other practices

Question	Y/N
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 easy read format.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified	The practice had identified 38 patients as carers (1% of the practice list).
How the practice supports carers	There was information available on the practice website to support carers and in the practice. Carers were offered an annual vaccination against flu. Notices in the practice waiting area encouraged patients to identify themselves as carers.
How the practice supports recently bereaved patients	The practice contacted bereaved patients as needed. They offered support and a telephone or face-to-face appointment as necessary.

## Privacy and dignity

Question	Y/N
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Yes

	Narrative
Arrangements to ensure confidentiality at the reception desk	The reception desk was screened with glass with a window for patients to speak to staff; this helped to muffle conversation. Staff knew that if a patient needed to be speak privately they could use a separate area.



Question	Y/N
Consultation and treatment room doors were closed during consultations.	Yes
A private area was available if patients were distressed or wanted to discuss sensitive issues.	Yes

Examples of specific feedback received:

Source	Feedback
Comments cards	Patients said their privacy and dignity were respected. They said staff made them feel safe and comfortable.
Patient interviews	Patients confirmed they felt at ease when seeing staff and GPs and confirmed they knew they could ask for a chaperone if they needed one.

# Responsive

## Responding to and meeting people's needs

Practice Opening Times	
Main surgery site, Croston	
Day	Time
Monday	8.30am – 7.30pm
Tuesday to Friday	8.30am – 6.30pm

Branch surgery site, Eccleston	
Day	Time
Tuesday	3pm – 5pm
Friday	3pm - 5pm

Appointments available	
Main surgery site, Croston	
Monday	8.30am – 10.30pm and 3.30pm – 7.30pm
Tuesday	8.30am – 10.30pm
Wednesday	8.30am – 10.30pm and 3.30pm - 6pm
Thursday	8.30am – 10.30pm and 4pm – 6pm
Friday	8.30am – 10.30pm

Branch surgery site, Eccleston	
Tuesday	3pm – 5pm
Friday	3pm – 5pm

Home visits	Y/N
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention	Yes
If yes, describe how this was done	
Staff recorded all requests for home visits with as much detail as possible so the GP could assess the level of need before the visit. Staff were aware of patient symptoms that required immediate attention and would interrupt the GP if necessary to pass on information.	

## Timely access to the service

### National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
3911	226	111	49.12%	2.8%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who were 'Very satisfied' or 'Fairly satisfied' with their GP practices opening hours. (01/01/2017 to 31/03/2017)	86.3%	85.1%	80.0%	Comparable to other practices
The percentage of respondents to the GP patient survey who gave a positive answer to "Generally, how easy is it to get through to someone at your GP surgery on the phone?" (01/01/2017 to 31/03/2017)	88.6%	70.5%	70.9%	Comparable to other practices
The percentage of respondents to the GP patient survey who stated that the last time they wanted to see or speak to a GP or nurse from their GP surgery they were able to get an appointment (01/01/2017 to 31/03/2017)	98.3%	78.8%	75.5%	Significant Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2017 to 31/03/2017)	95.1%	76.0%	72.7%	Variation (positive)

#### Any additional evidence or comments

The practice offered open access surgeries every weekday morning at Croston between 8.30am and 10.30pm and at the branch site at Ecclestone on Tuesday and Friday afternoons between 3pm and 5pm. Any patient who arrived at the practice during these surgeries were able to wait to see a GP. Afternoon surgeries at Croston were by appointment and we saw that on the day of our inspection, the next available appointment with a GP was in two working days.

### Examples of feedback received from patients:

Source	Feedback
Comments cards	Patients praised the ease with which they could see a GP and commented the daily open surgeries were very beneficial.

## Listening and learning from complaints received

Complaints	Y/N
Number of complaints received in the last year.	3
Number of complaints we examined	2
Number of complaints we examined that were satisfactorily handled in a timely way	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman	0
<b>Additional comments:</b>	
The practice kept an ongoing summary of complaints received so that any trends could be identified.	

Example of how quality has improved in response to complaints
One patient complaint required the practice to reflect on the end of life care offered to patients and the provision of some community services. This did not lead to change but there was a better understanding of the community services involved.

# Well-led

## Leadership capacity and capability

### Examples of how leadership, capacity and capability were demonstrated by the practice

We saw evidence of a lack of leadership in many areas of the practice. Following the departure of the practice manager in January 2018, GPs told us they had been unable to recruit a new manager. A new practice manager had been recruited in February 2018 but had worked at the practice for less than one week. They had then employed a practice manager from another GP practice for an average of nine hours a week. We saw evidence this did not allow for the governance of the practice to be maintained comprehensively:

- There was a lack of oversight of risk across the practice. Not all significant incidents were recorded and some safety checks were missing. Recruitment checks for temporary staff were not complete.
- There was no management oversight of clinical membership of professional bodies or medical indemnity.
- There was a lack of resources to offer staff meaningful support and appraisal. A new permanent practice manager had not been recruited.
- There was insufficient emphasis on staff training.
- Leaders demonstrated a lack of understanding of governance issues. The understanding of the necessity to embed process and procedures in everyday practice working was not evidenced. We were told many practice policies and procedures were rewritten and introduced in the days following our inspection.

## Vision and strategy

### Practice Vision and values

The practice statement of purpose was given to us before our inspection as:

“To deliver general medical services in a safe and effective manner, which is appropriate for the patient’s needs. Keeping in mind the patient’s need for respect, dignity and confidentiality.

This service is provided by screening, diagnosing and treating and referring to appropriate agencies as deemed fit.”

Staff were not aware of this statement although they told us they always tried to offer the best possible service to patients.

The practice had not developed an effective strategy to manage the governance of the practice.

## Culture

### Examples that demonstrate the practice culture

We saw evidence of a clinical audit programme, supported by the practice medicines co-ordinator and peer discussion that demonstrated that areas of patient care and treatment were reviewed and monitored. Staff reported that it was easy to discuss clinical issues with GPs. However, systems associated with other areas of practice services such as infection prevention and control and the regular review of all vulnerable children and young people were missing or incomplete. Significant

incidents were not always recorded and opportunities to identify learning and make improvements were missed.

There was no management overview of staff training. Managers did not place value on formal appropriate training for all staff; a new member of staff had received no formal training for the first three months in post and another staff member had not been supported in a request for training to support a new role.

Staff appraisals conducted by a GP had been very brief and without meaning; staff reported they lasted around five minutes. Staff reported feeling unsupported by managers.

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

Source	Feedback
Interviews with staff	We were told that GPs were very approachable and supportive regarding issues associated with patient care and treatment. However, staff said that GPs were very busy and had little time for staff support. Staff told us there were insufficient administrative and management resources and GPs carried out many administrative tasks themselves. This also contributed to GPs involving themselves unnecessarily in allocated staff roles. Staff also reported friction between GPs that was often openly expressed which caused staff anxiety.

#### Governance arrangements

Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.	
Practice specific policies	<p>Management of practice policies and procedures was poor. We saw that there were different versions of the same policy on the practice computer. Some policies were out of date and some were not practice-specific, for example, the practice fire safety policy had not been completed with the names of staff nominated for lead roles, neither had staff been nominated, and the recruitment policy spoke of being a training practice. Both plan policies were indicated as being recently reviewed. Some policies were missing, for example the safeguarding adults policy. The practice asked for this policy from the practice manager who had been assisting the practice but who was not in the practice at the time of the inspection and a policy was emailed which was then stored on the practice computer. We saw that this policy was very brief and did not follow best practice guidelines; there was no practice lead named in the policy and no detailed description of signs of abuse for staff reference. The practice sent us a revised policy following this.</p> <p>We saw evidence that policies and procedures were not embedded into practice and were not followed. For example, staff were not following the policy guidance for infection prevention and control or for fire safety. Staff told us although they were aware of policies on the computer they could access if needed, they rarely did so.</p>
Staff meetings	The practice held regular staff meetings to ensure good communication channels were maintained. Minutes of these meetings were available on the practice shared computer drive. Minutes evidenced discussion of quality improvement issues such as significant events and patient safety alerts although there was no set agenda. Staff reported a lack of time in

	meetings to deal with everyday service issues.
	<b>Y/N</b>
Staff were able to describe the governance arrangements	Yes
Staff were clear on their roles and responsibilities	Yes

## Managing risks, issues and performance

<b>Major incident planning</b>	<b>Y/N</b>
Major incident plan in place	Yes
Staff trained in preparation for major incident	No
<p>Explanation of any answers:</p> <p>We saw there was a plan in place although information contained in the plan was out of date, even though it was indicated as reviewed in March 2018. The plan named and gave contact numbers for organisations that no longer existed, for example the out of hours service that had ceased to operate in 2016.</p> <p>There had been no fire drills carried out for over a year and some staff had not taken part in any fire drills. Some staff knew there was a plan for dealing with major incidents, although they were not familiar with the contents. They said they would ask the GPs for advice if needed or look for the plan on the computer.</p>	

## Examples of actions taken to address risks identified within the practice

<b>Evidence</b>
<p>The practice did not use a confidential health questionnaire to assess and mitigate any possible risks to staff working arrangements. They told us that they would do this in future and for the newest staff member.</p> <p>The latest risk assessment for the premises and risks to staff and patients that was done in June 2018 was based on an old assessment done in January 2016 and had not been updated to reflect possible current risks. Some risks that had been removed and were associated with the previous premises configuration before the office for the practice manager was reconfigured, were indicated as checked. The infection control audit had not been done for over two years and actions identified in 2016 relating to COSHH data sheets had not been carried out. GPs were unaware of the necessity to have these sheets in place.</p> <p>There was no risk assessment for legionella for the practice water system or any recording of water temperatures to mitigate risks associated with the presence of legionella despite two annual "service check" certificates, the earliest dated 10/11/2016 that clearly indicated this should be done. Managers had not understood from these certificates this was necessary and thought this was all that was needed to ensure legionella was not present.</p> <p>There was no evidence of a building electrical safety certificate.</p> <p>Fire extinguisher checks had not been carried out since 2014.</p> <p>The infection prevention and control policy required that service level agreements (SLAs) were in place for the cleaning of the premises and that regular audit was carried out. There were no documented SLAs or audits. A GP told us that they carried out a visual inspection from time to time.</p>



## Appropriate and accurate information

Question	Y/N
Staff whose responsibilities include making statutory notifications understood what this entails.	Yes
Additional comments: Before our inspection, the clinical commissioning group (CCG) told us mandatory reports required to be submitted to the CCG on a regular basis were not sent in a timely way and were often late.	

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

### Feedback from Patient Participation Group (PPG);

Feedback
<p>The practice PPG was a group of patients who said that they met up about twice a year. There were no documented minutes for this group for us to view and no terms of reference. The PPG members we spoke to said they thought it was around November 2017 when they last met. They told us that they were only contacted before a meeting was planned. They were told of service developments at meetings and asked for suggestions for improvements.</p> <p>Patients said that they had contributed to improvements in the practice such as the introduction of the television screen in the waiting room to call patients and give health information and notices outside the practice to prevent patients parking in certain areas.</p> <p>There were forms left out for patients to complete for the Friends and Family Test (FFT). However, at the time of our inspection, these were on the reception counter under a bowl of empty patient specimen pots.</p>

## Continuous improvement and innovation

Examples of improvements demonstrated as a result of clinical audits in past two years

Audit area	Improvement
Audit of patients taking warfarin (a blood-thinning medicine).	The practice protocol for monitoring patients taking warfarin was reviewed and changed to make it more accurate and comprehensive. Staff were trained in this new procedure.
Audit of patients referred urgently under the "two-week wait" rule.	GPs were reminded of the criteria for referral for patients with suspected breast cancer.

Any additional evidence
<p>The practice had been inspected previously on 15 November 2016, 28 June 2017 and 23 January 2018. At these inspections, we rated the key question of Well-led as requires improvement generally for issues related to the governance of the practice. This had begun to be addressed by a newly-appointed practice manager following our first inspection. This manager had left in January 2018 and we saw that arrangements in place at the time of this inspection to ensure that governance systems operated effectively and safely were inadequate. This was therefore the fourth time that we found breaches of regulations related to the governance of the practice.</p>

**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, a statistical tool which shows the deviation from the England average. It gives us a statistical measurement of a practice's performance in relation to the England average, and measures this in standard deviations. We calculate a z-score for each indicator, thereby highlighting the practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are +2 or more or -2 or less are at significant levels, warranting further enquiry.

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

The following language is used for banding variation:

- Significant variation (positive)
- Variation (positive)
- Comparable to other practices
- Variation (negative)
- Significant variation (negative)

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95%.

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: <http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices>

**Glossary of terms used in the data.**

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework (see <https://qof.digital.nhs.uk/>).
- **RCP:** Royal College of Physicians.
- **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.( [See NHS Choices for more details](#)).