

Care Quality Commission

Inspection Evidence Table

Grosvenor Medical Centre (1-556239774)

Inspection date: 9 December 2019

Date of data download: 11 November 2019

Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Effective

Rating: Good

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.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
Explanation of any answers and additional evidence:	
National Institute for Clinical Excellence (NICE) guidance and quality standards were reviewed regularly at clinical meetings. There was a lead GP for the process and learning was shared with the team and changes implemented if appropriate. A clinical representative attended locality and Clinical Commissioning Group (CCG) events. Bi-weekly in-house education meetings were held.	

Prescribing	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) (01/07/2018 to 30/06/2019) (NHSBSA)	0.62	0.61	0.75	No statistical variation

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out medication reviews for patients over 80 and on ten or more medications to ensure safe and effective prescribing.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Staff had received training in manual handling and were aware of how to support the frail elderly with regards to falls.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice accessed a community intervention beds (based in a community hospital) scheme which meant patients could be supported in the community rather than go to hospital. The practice visited and reviewed the needs of these patients.
- The practice referred patients to a community advanced clinical practitioner and complex case managers who provided acute interventions and arranged follow-up services which helped to reduce the need for a patient to be admitted to hospital.
- Patients were referred to health and social care services to meet their needs. For example, patients over 65 were referred to a falls and exercise programme.

People with long-term conditions

Population group rating: Good

Findings

Patients with a long-term condition were offered an annual review to check their health and medication needs were being appropriately met. Patients with multiple conditions had their reviews coordinated to reduce the number of visits to the practice.

Staff who were responsible for reviews of patients with long-term conditions had received specific training.

Multi-disciplinary meetings were held with social and health service practitioners to review patients with complex and palliative care needs to ensure they had access to appropriate support.

The practice referred patients to the Integrated Respiratory Team when they experienced an exacerbation of chronic obstructive pulmonary disease.

The practice had introduced Feno testing to assist with respiratory diagnosis.

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 atrial fibrillation were assessed for stroke risk and treated appropriately.

The practice was part of a large project being delivered by Merseyside and Cheshire health care partnerships and Liverpool Heart and Chest hospital to increase cardiovascular outcomes for patients in the locality.

Diabetes Indicators	Practice	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 (01/04/2018 to 31/03/2019) (QOF)	68.4%	80.1%	79.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	8.0% (76)	14.1%	12.8%	N/A
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 (01/04/2018 to 31/03/2019) (QOF)	77.2%	81.2%	78.1%	No statistical variation
Exception rate (number of exceptions).	7.1% (68)	10.5%	9.4%	N/A

	Practice	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 (01/04/2018 to 31/03/2019) (QOF)	58.0%	74.5%	81.3%	Significant Variation (negative)
Exception rate (number of exceptions).	13.9% (133)	19.9%	12.7%	N/A

Other long-term conditions	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, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) (QOF)	69.8%	74.6%	75.9%	No statistical variation
Exception rate (number of exceptions).	1.8% (17)	6.9%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	92.2%	89.8%	89.6%	No statistical variation
Exception rate (number of exceptions).	13.9% (54)	14.9%	11.2%	N/A

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 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)	81.7%	83.0%	83.0%	No statistical variation
Exception rate (number of exceptions).	1.7% (36)	3.5%	4.0%	N/A
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 (01/04/2018 to 31/03/2019) (QOF)	85.6%	89.7%	91.1%	No statistical variation
Exception rate (number of exceptions).	1.6% (4)	5.7%	5.9%	N/A

Any additional evidence or comments
Two of the indicators for patients with diabetes were lower and significantly lower than local and national

averages. These indicators related to the number of patients where test results showed cholesterol and blood sugar levels were at appropriate levels. The practice had a plan in place to try to improve these results. The practice was reviewing patients and discussing the importance of making lifestyle and dietary changes. They referred patients to a diabetes prevention programme. They promoted services to improve patient health. The practice was planning to introduce group consultation training for diabetes and the practice was looking at a slimming clinic utilising the premises. The practice had trained two nurses to be prescribers, so medication could be reviewed during long term condition reviews. The data we reviewed showed that improvements were being made to the number of patients having their diabetes reviewed.

Families, children and young people

Population group rating: Good

Findings

- The practice had met the minimum 90% target for all four childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all four childhood immunisation uptake indicators. The provider informed us that a challenge to uptake had been families moving out of the area and the country but remaining on the records of the practice as requiring vaccination.
- To improve uptake the provider had set up a steering group and reviewed non-attenders. They actively monitored the waiting list for immunisations to allow appointment capacity to be adjusted as required to maintain a low waiting time and therefore increase the chance of attendance. Other action taken to encourage uptake included opportunistic screening, flexible appointment times, contacting the health visiting service when appointments were missed to encourage attendance and GPs contacting patients to encourage attendance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and liaised with health visitors when necessary.
- The practice referred patients to the Family Nurse Partnership programme which supported young mothers for the first two years of parenthood.
- The practice worked closely with midwifery services to support patients where complex social factors, poor mental health or pregnancy issues had been identified.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- Young people could access services for contraception and were signposted to a local service for sexual health.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of	137	147	93.2%	Met 90% minimum

immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) (i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)				
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	127	140	90.7%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	130	140	92.9%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	129	140	92.1%	Met 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>

Working age people (including those recently retired and students)

Population group rating: **Good**

Findings

- Patients had access to appropriate health assessments and checks including NHS checks. The clinicians told us there was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery. In-house services were offered to meet the needs of this population group such as minor surgery, contraceptive services and a range of in-house tests such as spirometry, 24-hour blood pressure monitoring, phlebotomy and D-dimer testing (a blood test used to help rule out the presence of a serious blood clot).

Cancer Indicators	Practice	CCG average	England average	England comparison
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) (01/04/2017 to 31/03/2018) (Public Health England)	69.0%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	73.1%	74.9%	72.1%	N/A

Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	52.3%	60.3%	57.3%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	62.1%	70.6%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	61.6%	57.4%	51.9%	No statistical variation

Any additional evidence or comments

Cervical cancer screening was below the 80% coverage target. The practice had a quality improvement plan to increase the uptake of cervical screening. This showed the practice had offered a variety of appointments at different times, including early morning extended hours, home visits were appropriate and a Saturday clinic through the summer. The practice had made this screening available to book on line, clinicians contacted a small number of non-attenders to directly book appointments to see if this reduced the risk of missed appointments. The practice ran a promotional campaign within the practice waiting area, met with Public Health England to discuss how the screening rates could be increased and opportunistic screening was offered. The practice regularly audited the screening uptake. The practice had mentors who were able to supervise the training of new GPs and nurses in cervical screening and therefore increase the number of staff able to carry out this procedure. The practice sent reminder letters and sample taking was monitored to reduce the occurrence of repeat attendance.

The practice completed a national Macmillan toolkit to review cancer care from prevention and screening to palliative care. This resulted in working with the Action on Cancer team to encourage non-attenders to attend bowel cancer screening. Bowel screening had been promoted through the TV screen in the waiting area, reminder letters and text messaging. Breast cancer screening was also promoted by the practice.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients who were vulnerable and had a system to review the needs of these patients. This included patients with a learning disability, frail patients, patients with dementia and patients with a debilitating illness. There was also a system to review any missed appointments by patients on this register.
- The register of patients with a learning disability was reviewed annually with the learning disability team from social services to ensure the register was correct and to discuss concerns and ways to address any issues identified.
- Clinical staff kept a record of tests requested for vulnerable patients to ensure these were

completed.

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice worked closely with the social prescribing service to refer patients where social issues were affecting their health and well-being.

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

Population group rating: Good

Findings

- The practice maintained a register of patients who experienced poor mental health. The register supported clinical staff to offer patients experiencing poor mental health an annual health check and a medication review.
- There was a system for following up patients who failed to attend appointments or collect their prescriptions.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Staff had received training to enable them to support patients with poor mental health.
- Clinical and non-clinical staff had undertaken training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Alerts were added to patients records if there was a (DoLS) in place.
- The practice hosted mental health services which made access easier for patients.
- The practice was piloting a Mental Health First clinic run by a trained mental health nurse. This was for patients with issues relating to anxiety, depression and bereavement. Patients were signposted by any member of the team, including reception staff.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	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 (01/04/2018 to 31/03/2019) (QOF)	90.0%	92.4%	89.4%	No statistical variation
Exception rate (number of exceptions).	9.1% (16)	12.7%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	85.2%	89.7%	90.2%	No statistical variation
Exception rate (number of exceptions).	8.0% (14)	10.2%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	80.0%	81.9%	83.6%	No statistical variation
Exception rate (number of exceptions).	7.6% (7)	7.0%	6.7%	N/A

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.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	524	No Data	539.2
Overall QOF score (as a percentage of maximum)	93.7%	No Data	96.4%
Overall QOF exception reporting (all domains)	5.5%	No Data	No Data

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

past two years

- Audits in the last 2 years included an audit of gout monitoring. This was based on NICE guidelines and involved an initial and a re-audit. This resulted in an improvement in patient monitoring and in the number of patients who had a documented management plan in their notes. An action plan to promote further improvements was also in place.
- An audit of treatment for sore throats showed this was based on evidence-based guidelines and involved an initial and a re-audit. This resulted in an increase in the use of the Fever Pain Score which guided appropriate prescribing and reduced antibiotic prescribing. Posters were displayed in clinical rooms regarding antibiotic prescribing and a learning session took place on NICE guidelines.
- The practice was also undertaking quality monitoring work around appropriate prescribing. For example, looking at polypharmacy and the use of psychotropic medication.

Any additional evidence or comments

- There was a comprehensive system for reviewing unplanned admissions to hospital to enable appropriate action to be taken. A monthly review of all unplanned admissions took place and a certain clinical area or patients were looked at in more detail to identify any missed opportunities for action or learning needs.
- One of the GPs was a local reviewer of referrals and fed back learning to the practice. Referral audits were also discussed at clinical meetings.

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. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y

The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	
<p>There was a system in place to monitor the training needs of staff. The provider told us they ensured that all locum staff had completed training to ensure the safety of patients and safe working practices such as safeguarding adults and children and basic life support. We looked at a sample of training records and certificates that supported this.</p> <p>A locum pack was available for clinicians to refer to that included information about the policies and procedures of the practice, contact details for relevant individuals and organisations and guides to processes such as making referrals, scans and blood tests.</p> <p>There was a good system in place to ensure staff were supported. The trainee staff had a structured system of support in place. The practice received the gold award for excellence in teaching in 2019 as a result of feedback from medical students.</p> <p>All non-partner clinical staff had a named mentor and designated mentorship time each week. The salaried GP had regular reviews of their work and had an in-house and an external appraisal.</p> <p>Bi-monthly practice nurse supervision also took place. An advanced nurse practitioner co-ordinated a supervision group for advanced nurse practitioners in the area. The members of staff delivering the supervision had received training to provide this.</p> <p>The practice ensured that staff employed in advanced clinical practice were supported and had weekly meetings to review consultations, prescribing and referrals.</p> <p>There was a system for referrals to be externally audited and peer review of referrals also took place.</p>	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

Explanation of any answers and additional evidence:

The staff we spoke to told us how they ensured that patients received consistent, coordinated, person-centred care when they moved between services.

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice was proactive in helping patients live healthier lives. For example, alcohol consumption was screened at new patient checks, referrals were made to local exercise services, travel vaccinations and health travel advice was offered. Ultrasound, dermoscopy and 24-hour blood pressure monitoring were available at the practice.</p> <p>The practice had signed up to the Active Cheshire Pledge to improve health in the area. The practice was a Parkrun practice and promoted this to patients.</p> <p>Designated influenza immunisation clinics were held at weekends and involved third sector groups to promote health projects and screening.</p>	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record	92.3%	95.2%	95.0%	No statistical variation

smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>				
Exception rate (number of exceptions).	0.6% (21)	0.5%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Clinicians told us how they supported patients to make decisions. Where appropriate, they told us they assessed and recorded a patient's mental capacity to make a decision.</p>	

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.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	
<p>The provider told us how they ensured that services were delivered and organised to meet patients' needs. For example, home visits were undertaken for patients unable to visit the practice due to their health. Information was available in easy read and pictorial format and could be made available in large print. The practice had systems in place to ensure the needs of patients on trans-care pathways were considered.</p> <p>The practice had made changes to the premises to improve patient care. For example, there was a low-level reception desk, visual and auditory patient call system, bariatric seating, high back arm chair and rests and braille numbering on doors.</p>	

Practice Opening Times – Grosvenor Medical Centre	
Day	Time
Opening times:	
Monday	7am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	7am – 5.50pm
Tuesday	8.40am – 5.50pm
Wednesday	8.40am – 5.50pm
Thursday	8.40am – 5.50pm
Friday	8.40am – 5.50pm

Practice Opening Times – Gresty Brook Medical Centre	
Day	Time
Opening times:	
Monday	8am – 6pm
Tuesday	8am – 7.30pm
Wednesday	8am – 6pm
Thursday	8am – 6pm
Friday	8am – 5pm
Saturday	8am – 11.30am
Appointments available:	
Monday	8.40am – 5.50pm
Tuesday	8.40am – 7.15pm
Wednesday	8.40am – 5.50pm
Thursday	8.40am – 5.50pm
Friday	8.40am – 4.30pm
Saturday	8am – 11.30am

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
14173.0	329.0	110.0	33.4%	0.78%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	92.0%	95.2%	94.5%	No statistical variation

Any additional evidence or comments

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> All patients had a named GP who supported them in whatever setting they lived. The practice was responsive to the needs of older patients and offered home visits, longer appointments and urgent appointments for those with enhanced needs and complex medical issues. Advanced nurse practitioners provided annual reviews for patients living in care and nursing homes.

- Extended hours services were offered so that relatives could accompany patients to appointments.
- The practice ran a flu clinic for over 65-year-old patients on a Saturday in September and October 2019.
- The practice provided effective care coordination to enable older patients to access appropriate services.

People with long-term conditions

Population group rating: Good

Findings

- Early morning and late evening appointments were offered, and the practice was also open every Saturday offering long-term condition appointments. Home visits were also made to patients unable to attend the practice.
- Text messages and reminder prompts were sent to patients to ensure they received the care and treatment needed. At busy periods such as Christmas there were arrangements to remind patients that prescriptions needed to be presented in good time to allow for the holidays and to ensure all requests for telephone calls and queries were met.
- Patients with multiple conditions had their needs reviewed in one appointment where possible.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- The nurses had developed a wound care clinic in response to patients' needs. This enabled the practice to assess the issues underlying the wounds and to offer a full holistic assessment. The nurses had also introduced a new template to promote early leg ulcer prevention. There was a plan in place for a community leg club to be opened in February 2020. This had been developed by the Primary Care Network and would involve both health and social care for patients.
- All new diabetic patients were referred to a structured diabetic education programme. The practice had recently met with the community nursing team to review the care of diabetic patients at home. This resulted in improved communication and a named lead to liaise with the community nursing team.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Good

Findings

- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice provided six-week baby checks, weekly immunisation clinics and telephone advice. These services were accessible during and outside school hours by appointment.
- Extended hours appointments were available which meant school age children did not need to

miss school.

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had attended accident and emergency (A&E) were reviewed to identify and address any issues.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice offered a range of appointments for both the GP and nursing team. This included routine and urgent appointments, home visits and telephone consultations. Appointments could be booked in person, by telephone, on-line or via mobile applications (apps). Prescriptions could be managed on-line. A text messaging service reminded patients about appointments. The practice offered extended access 7am-8am on Monday mornings and 6.30pm to 7.30pm on Tuesday evenings.
- In-house services were offered to meet the needs of this population group such as minor surgery, contraceptive services and a range of in-house tests such as spirometry, 24-hour blood pressure monitoring, phlebotomy and D-dimer testing (a blood test used to help rule out the presence of a serious blood clot).

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Longer appointments were available. Alerts were placed on patient records so that additional assistance could be offered. Translation services could be accessed. The practice had employed a multi-lingual receptionist in response to the increase of patients from Eastern Europe.
- The practice maintained a register of potentially vulnerable and isolated patients. The practice had developed searches to identify these patients. A template was then developed and used during consultations or a specific telephone call was made to identify areas the patient may need help with and a referral made based on the needs identified. There was a plan in place to review this provision to determine its effectiveness and impact on patient outcomes.
- People in vulnerable circumstances were easily able to register with the practice. For example, the practice provided a service to a women's refuge and had an established relationship with this service which encouraged women to register.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- Advanced nurse practitioners were participating in a Skype project with a nursing home to trial innovative ways of working with patients.
- A carers register was held. Carers were identified and provided with relevant information about GP and local services. Information for carers was publicised and carers were offered an influenza vaccination. Young carers were identified during palliative care meetings and a plan to support them was put in place.
- The practice worked closely with the social prescribing service to refer patients where social issues were affecting their health and well-being.

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

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted patients to these accordingly.
- The practice had upskilled the nursing team and advanced nurse practitioners around identifying and managing poor mental health.
- The practice was working with the Primary Care Network (PCN) and children's mental health services to better understand referral criteria and maximise the effectiveness of consultations and referrals.
- The practice provided a GP service for young people with poor mental health residing in a local specialist service.

Timely access to the service

People were able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence:	

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 (01/01/2019 to 31/03/2019)	40.2%	N/A	68.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	54.0%	66.6%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	49.4%	65.7%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	58.1%	75.2%	73.6%	Tending towards variation (negative)

Any additional evidence or comments
<ul style="list-style-type: none"> The practice reviewed feedback received from patients through the National Patient Survey, complaints, PPG and the Family and Friends survey and took steps to address issues identified. The practice had taken a number of actions to address the shortfalls identified by the National Patient Survey. A new telephone system had been installed at Gresty Brook Medical Centre. Changes had been made to the telephone system at Grosvenor Medical Centre, for example, to allow for call queuing and a new telephone system was planned for December 2019. Telephone access would then be able to be monitored at both services.

- The practice had increased the number of appointments offered. The practice offered on-line booking of appointments and medication ordering. The practice also offered access to appointments through the MyGP mobile computing application and a text messaging service. This service was being publicised to increase uptake and reduce the number of telephone calls to the practice.
- The appointment system was monitored to ensure it met the demand for appointments. This was monitored by the practice management team and with the partners at business strategy meetings.
- The practice had reviewed the services offered and made changes to meet the needs of patients. For example, they had employed advanced nurse practitioners and a pharmacist and were providing further training to the clinical team to develop their skills and make further staff resources available. The practice had introduced the new role of advanced clinical practitioner.
- The practice was piloting a Mental Health First clinic run by a trained mental health nurse. This was for patients with issues relating to anxiety, depression and bereavement. Patients were signposted by any member of the team, including reception staff.
- A triage system had been developed and was having a positive effect on the use of resources.
- Staff had been trained in Signposting. This training provided staff with knowledge about ensuring patients were directed to the right clinician, appointment type or external service to meet their needs.
- Staff had also been trained in Releasing Time for Care to reduce the time spent by clinicians on administrative tasks and provide more time for patient care.
- The practice had a range of clinicians and offered different types of appointments such as telephone consultations, home visits, urgent appointments, book in advance appointments, pharmacy reviews and assessments and extended hours on Monday mornings and Tuesday evenings. The practice also opened on a Saturday morning. The practice did not close for half a day or in the afternoon.
- The practice made minimum use of locum clinicians to promote continuity of care.
- The practice had regular contact with the nursing home it provided a service to so that the needs of patients could be anticipated.
- The practice was planning to pilot video consultations.
- Cheshire and Vale Royal GPs offered extended hours appointments at selected practices in the evening and at the weekend (GP hub). This was hosted at the practice on a Friday evening, Saturday and Sunday.
- An audit of the extended access service found it was well used by patients.
- The practice had made a number of changes to improve access. The practice sought patient feedback by utilising the NHS Friends and Family test (FFT). The FFT is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014. Results from December 2018 to November 2019 showed there had been 1225 responses and 86% were either extremely likely or likely to recommend the practice.
- However, the practice had not taken action to demonstrate that patient satisfaction with access in the specific areas identified in the National Patient Survey had improved. The practice was working with the PPG on a survey to be undertaken within the next three months to assess the impact of the changes made and to plan for further changes if needed.

Source	Feedback
Comment cards	We received five comment cards. Four were positive and comments were made about the staff being helpful, caring and professional. One comment card was negative and related to the care and treatment provided.

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.	18
Number of complaints we examined.	1
Number of complaints we examined that were satisfactorily handled in a timely way.	1
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <p>An annual meeting was held to review complaints. Complaints were monitored to identify any patterns or trends. Learning from complaints and compliments were discussed with the staff team.</p> <p>Concerns raised by patients who did not wish to complain were also recorded and this demonstrated the action taken. We discussed how these concerns were investigated as this was not clearly documented.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Medication not prescribed.	The practice did not prescribe this medication as it did not consider the secondary care arrangements in place for shared care were robust. This resulted in meetings with secondary care which provided the practice with reassurance. An action plan was developed, and policies updated to govern shared care working.

Well-led

Rating: Good

Leadership capacity and capability

Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	
A written plan was in place for the development of the service. This was reviewed at business strategy meetings. The plan included staff development, improvements to information technology and improvements to the premises.	
We also saw quality improvement plans for direct patient care. For example, for increasing patient access to cancer screening and screening for long-term conditions and immunisations.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Regular staff meetings took place to ensure clear and effective communication. There was a system of support in place for staff which included supervision, mentorship and appraisal.</p> <p>A news bulletin for staff was provided giving staff information on the latest news and updates. For example, information about training events, flu clinics and fund raising.</p> <p>Freedom to speak up was advertised at the practice.</p> <p>The provider told us there was a culture of praise at the practice and that they informed staff when they were working well. The provider had an "extra mile" award where staff voted each month for a colleague who deserved recognition for their efforts.</p> <p>In 2019 two of the nursing staff were given the Queens Award. The nurses were supported by patients and colleagues and received the award for commitment to patient care, learning and leadership.</p>	

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

Source	Feedback
Interviews with staff	<ul style="list-style-type: none"> Staff stated they felt supported. They had access to the training they needed for their roles and were encouraged to develop their skills.

	<ul style="list-style-type: none"> • Staff told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed. • They told us there was good communication between all staff.
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Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff had responsibility for different areas. For example, there was a lead member of staff who monitored the quality indicators, lead for safeguarding, medicines management, carers and complaints.</p> <p>The practice held a range of meetings. There was a monthly management meeting and additional strategy meetings as required to assess and review major changes to practice. Regular staff meetings, nurse meetings, clinical meetings (GPs and advanced nurse practitioners (ANPs)) and administrative staff meetings were held. All issues that had an impact on the running of the service were discussed at these meetings including significant events and complaints. A record was made and distributed to the staff team.</p> <p>The trainee staff had a structured system of support in place. All non-partner clinical staff had a named mentor and designated mentorship time each week. The practice ensured that staff employed in advanced clinical practice were supported and had weekly meetings to review consultations, prescribing and referrals.</p>	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y

There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
Quality improvement and audit systems were in place and assisted the practice to make changes to improve the service provided.	
There were effective arrangements in place to identify, manage and mitigate risks. There were systems to ensure that staffing levels were sufficient to satisfy patient demand. The management team monitored demand for appointments and capacity to meet this. There were systems in place to receive and respond to patient safety alerts, significant events and complaints. There were systems to ensure that appropriate standards of cleanliness and hygiene were met and to ensure medicines were safely managed.	
There were systems to ensure the premises and equipment were fit for use. We checked a sample of risk assessments and equipment checks. We found that the emergency lighting had not been checked consistently on a monthly basis. A fire audit in September 2019 had identified this and monthly checks had taken place since then.	
There were systems in place to review and update policies and procedures and these were accessible to all staff. The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. Staff had training in safeguarding vulnerable adults and children and there were processes in place to respond to requests for information from the local authority. Annual safeguarding audits were undertaken. The most recent audit had identified that codes were not placed on the records of family members on a consistent basis. A plan to address this was in place.	

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 adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice monitored feedback from patients through surveys, the Patient Participation Group, complaints, NHS Choices and Health watch. The practice carried out surveys of patients views of the GPs performance and documented the results with any actions if required. The practice publicised actions taken as a result of patient feedback from the National Patient Survey.</p> <p>There were systems in place for staff to raise issues. There were regular staff meetings, with an agenda item for staff concerns. There was also an “issues box” for staff to raise any concerns or matters affecting their work.</p> <p>Healthwatch had visited the practice in May 2019 and said the practice was clean and welcoming with plenty of information available. Healthwatch made some recommendations for improvements which the practice had addressed.</p> <p>The practice had a newsletter for staff which had been re-introduced in September 2019.</p>	

Feedback from Patient Participation Group.

Feedback
The practice had a Patient Participation Group (PPG). We met with two members who told us that they generally met four times per year with a representative from the practice. They said they were kept informed about changes at the practice, asked their opinion and felt listened to. They said that changes had been made at the practice as a result of their feedback. For example, changes had been made to the layout of the reception area and to how reception was managed at busy times. The PPG were actively involved in local service design via the Crewe Care Community.

Any additional evidence
The practice sought patient feedback by utilising the NHS Friends and Family test (FFT). The FFT is an opportunity for patients to provide feedback on the services that provide their care and treatment. It was available in GP practices from 1 December 2014. Results from December 2018 to November 2019 showed there had been 1225 responses and 86% were either extremely likely or likely to recommend the practice.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had taken part in pilots to improve the services offered to patients. For example, they had been part of the Mental Health First pilot and the Liverpool Heart and Chest pilot programme for reviewing patients with chronic obstructive pulmonary disease. The practice had also introduced Releasing Time for Care and staff had been trained in Signposting. The practice actively engaged with new models of care and hosted community heart failure clinics at Gresty Brook Medical Centre, social prescribing clinics and offered in-house ultrasound scanning clinics. The practice was currently piloting skype consultations and reviews with a local nursing home. There was a clear focus on staff development and learning. For example, a receptionist had been trained to become a health care assistant and then a physician assistant and a health care assistant had been trained to become an assistant practitioner and was training to become a nurse. The practice was also working with other health services to enable cross organisational placements for nursing staff. There was a comprehensive system for reviewing patients who had an unplanned admission to hospital. A monthly review of all unplanned admissions took place and a certain clinical area or patients were looked at in more detail to identify any missed opportunities for action or learning needs. The practice was actively involved in local systems and processes to develop improvement across the health system and improve services for patients. One GP partner was the clinical director of the local Primary Care Network (PCN), Clinical Lead for Community Care (engagement with local partner organisations such as education, mental health and ambulance services), Director of the Local GP Federation and actively involved in the development of the emerging local integrated care partnership. Two advanced nurse practitioners were lead nurses for the PCN. The practice provided training to fifth year medical students, GP registrars, physicians associates, student nurses, return to practice nurses and provided training for non-medical prescribers and cervical cytology mentorship. The practice received the gold award for excellence in teaching in 2019 as a result of feedback from medical students. The practice had so far mentored around 45 student nurses through primary care placements across the training hub practices. An advanced nurse practitioner co-ordinated a supervision group for advanced nurse practitioners in the area to meet the needs of this often-isolated role. The members of staff delivering the supervision had received training to provide this. The practice actively fund-raised for local charities. The practice had plans in place for future development that included the premises, workforce, service design and working with the PCN. 	

Examples of continuous learning and improvement

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the 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
- **PHE:** Public Health England
- **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.