

Care Quality Commission

Inspection Evidence Table

Four Acre Health Centre (1-600127824)

Inspection date: 06 March 2020

Date of data download: 25 February 2020

Overall rating: Requires Improvement

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

Safe Rating: Requires Improvement

We rated Safe as requires improvement because:

- Safeguarding policies did not provide staff with the information required to enable them to deal with all kinds of abuse in particular: female genital mutilation (FGM) and radicalisation (PREVENT); assurance could not be provided that staff had completed the required level of safeguarding training; recruitment and selection vetting did not include sufficient checks to ensure all staff were fit and proper to work with vulnerable people.
- Blank prescriptions were not kept secure.
- Required health and safety checks had not been completed.
- There was limited evidence of shared learning from significant events.
- Systems for managing staff needed to be strengthened, the immunisation status of staff had not been checked in-line with best practice guidance and staff had not completed training in several key safety topics for example, sepsis; fire safety and chaperone training.

Safety systems and processes

The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Partial
Policies took account of patients accessing any online services.	No
Policies and procedures were monitored, reviewed and updated.	Partial

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role.	No
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
Staff who acted as chaperones were trained for their role.	Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
<ul style="list-style-type: none"> There were safeguarding and child-protection reporting flow charts in the clinical and reception areas for staff to follow. <p>However:</p> <ul style="list-style-type: none"> The safeguarding policies and procedures had not been updated to include information about identifying and dealing with female genital mutilation or PREVENT (anti-radicalisation). There were no systems in place to manage staff training to ensure they had completed the correct level of adult safeguarding and child protection training or, completed chaperone training before carrying out that task. Staff could not recall the level of safeguarding training completed and the most recent documented chaperone training at the practice was in 2016. Clinical and medical staff had Disclosure and Barring (DBS) information in place however, DBS checks were not completed for administration staff and an assessment to review this risk had not been completed. Disclosure and Barring checks are meant to be completed to ensure only fit and proper people work with adults and children in vulnerable situations. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	No
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
<ul style="list-style-type: none"> Recruitment checks did not always include all the information necessary according to the regulations, missing items included, health declarations and copies of photographic identity. The practice indicated that a system was being introduced to ensure this information was logged. Vaccination status was not available for any staff. A process was being developed to ensure registrations were checked at the time of the annual appraisals. Checks indicated all clinical and medical staff were correctly registered. Certificates indicated clinical staff including Advanced Nurse Practitioners were qualified and registered for their roles. Indemnity insurance was up-to-date and all staff were covered. 	

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Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 19/12/2019	Yes
There was a record of equipment calibration. Date of last calibration: 19/12/2019	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Partial
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: 11/02/2020	Yes
There was a log of fire drills. Date of last drill: drills not recorded	No
There was a record of fire alarm checks. Date of last check:	Yes
There was a record of fire training for staff. Date of last training:	No
There were fire marshals.	Partial
A fire risk assessment had been completed. Date of completion: not available	No
Actions from fire risk assessment were identified and completed.	No
<ul style="list-style-type: none"> • The cleaning company had completed a Coshh assessment of the liquids and products they used however, assessments had not been completed for the products provided and used by the practice. • Fire drills had not been recorded however, an evacuation caused by a false alarm had been recorded. The practice indicated the evacuation went smoothly however, information did not include what went well or lessons learnt during the event. • The provider had not ensured a fire risk assessment was available for the building. • The role of Fire Marshall had been designated to staff but training or guidance about the role had not been provided. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: not available	No

Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: not available	No
<ul style="list-style-type: none"> Health and safety policies were in place however, these did not relate specifically to Four Acres medical centre. For example, the lone working policy mentions St Helens lone working practices but did not provide staff with instructions and guidance specifically relating to the practice. The practice had not provided staff with standard operating procedures for all the policies in place. Security needed to be strengthened as the entrance to the consulting rooms and back-office area was not kept locked and consultation rooms were not locked when unoccupied. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not fully met.

	Y/N/Partial
There was an infection risk assessment and policy.	Partial
Staff had received effective training on infection prevention and control.	No
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: February 2020.	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Partial
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<ul style="list-style-type: none"> The practice had not identified an infection control lead. The most recent infection control audit completed in February 2020 had given the practice three months to act on any issues identified and the practice was part way through this improvement plan. On the day of inspection, the surfaces in a number of consultations rooms were very cluttered and this did not meet infection prevention and control best practice. The fixtures and fittings in some areas did not meet best practice standards for example, the paint was flaking from a number of walls and many areas including some consultation rooms were carpeted. At the time of the visit there was a World Health Organisation public health concern (Coronavirus Covid-19). Best practice was for health services to display public health posters providing information about managing the illness, rules about not visiting the practice if they had been to certain countries and advice about self-isolation. The practice had not put these posters on display, the posters displayed were aimed at professionals, this was brought to the attention of the provider. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	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.	Partial
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Partial
Receptionists had completed basic life support training in July 2019. However, they had not completed sepsis training neither were sepsis care pathway posters provided in reception. The practice had not assessed and monitored the impact of GPs reducing their hours or changing from partners to salaried GPs.	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes

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
<ul style="list-style-type: none"> • Routine and urgent referrals were made via a task raised in the patients record. • The practice indicated that the urgent two-week wait referral list was checked weekly and action taken if an appointment had not been made. The added failsafe was to make the patient aware that the situation was urgent. • It was noted that an incident had occurred involving delayed referral for tests however, the provider had not shared learning or formalised the changes made as a result of this incident. 	

Appropriate and safe use of medicines

The practice needed to strengthen systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	1.35	1.05	0.87	Variation (negative)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) (NHSBSA)	7.4%	6.8%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)	5.86	5.98	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	4.38	2.67	2.08	Variation (negative)

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes

Medicines management	Y/N/Partial
Blank prescriptions were kept securely and their use monitored in line with national guidance.	No
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	No
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Not applicable
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 appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	n/a
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Partial
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<ul style="list-style-type: none"> • Blank handwritten prescriptions were not monitored and prescriptions were not removed from printers and stored securely when the building was empty. • Emergency equipment was in place and checked, excepting the emergency oxygen bottle which was less than half full. This was brought to the attention of the provider. 	

Track record on safety and lessons learned and improvements made

The practice did not have a system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	No
Number of events recorded in last 12 months:	3
Number of events that required action:	3
<ul style="list-style-type: none"> The practice did not have an incident reporting policy for staff to follow. Staff had not completed incident reporting training. Staff indicated that they would raise all concerns with a member of the management team. There was some evidence of shared discussion and learning between GPs. Administration staff could not recall a change made as a result of learning from an incident. The practice indicated that all safety events and incidents were entered onto a central reporting system provided by the local Clinical Commissioning Group (CCG). The provider had recorded three incidents that required investigation. 	

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

Event	Specific action taken
Aggressive behaviour	Detailed information about the event including who was involved however, no learning was recorded.
Missed referral between GP and secondary care	Information about the event was unclear; the investigation details indicated the investigation was not efficient. Event 2018; investigation 2019; reviewed 2020. Clinical meeting identified a discussion and learning from the event amongst GPs. No evidence of sharing wider learning or discussion. However, the practice had changed how they dealt with referrals which should have been by secondary care. This change had not been formalised.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	No
Staff understood how to deal with alerts.	Partial
<ul style="list-style-type: none"> The practice received information from different sources such as the Medical and Healthcare products Regulatory Agency (MHRA); Patient Safety Alerts (PSA); medical devices and medicines alerts. A system was in place for sharing the information however there was no system to confirm the action required had taken place. We saw examples of actions taken on recent alerts for example, regarding sodium valproate managed by the CCG medicines optimisation team. However, they had not acted appropriately on the COVID-19 alert. 	

Effective

Rating: Requires Improvement

We rated Effective as requires improvement because:

- The systems to ensure all care and treatment was in line with best practice guidance were not robust.
- The processes in place to promote public health initiatives for cervical screening were not effective.
- Staffing systems were not robust or embedded and the practice could not demonstrate that all the relevant training had been provided to and completed by clinical and operational staff.
- Clinical audits had not been completed.

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 which was supported by pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
<ul style="list-style-type: none"> • GP's were able to demonstrate that patients received care and treatment in line with best practice however, information about best practice protocols and care pathways was not readily available to and consistently used by GPs. • Advance nurse practitioners had access to up to date care pathways and best practice guidance on their computer desktops. 	

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) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	2.64	1.45	0.74	Significant Variation (negative)

Any additional evidence or comments

The practice identified that the prescribing of hypnotics needed to decrease and work was commencing with the CCG medicines optimisation team to look at ways of achieving safer prescribing. A prescribing protocol had not been introduced for GP's. The non-medical prescribers were aware of the best practice prescribing guidance for high risk medicines and antibiotics however, their prescribing was not monitored.

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.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- The practice carried out structured annual medication reviews for older patients.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- Data indicated that some outcomes for this population group was significantly below local and national averages in particular the prescribing of hypnotics and appropriate anti-coagulation therapy.

However:

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met, however, there was no evidence of co-ordinated packages of care.
- The practice nurse followed up all patients who had received treatment in hospital or through out of hours services.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice liaised with a number of secondary care teams in particular diabetes, respiratory and urology.

- The practice held a monthly joint clinic with the diabetes nurse specialist and was a pilot practice for this CCG led project.
- Discharge summary's received in practice were reviewed by a clinician within 48 hours of receipt and all relevant action was taken including contact with the patient.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Data indicated that patients with atrial fibrillation were not routinely assessed for stroke risk and treated appropriately.
- The practice reported that patients with COPD were offered rescue packs.
- Patient records indicated patients with asthma were offered an asthma management plan.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training, however, there was no overview to ensure all training was up to date and clinicians informed about how to continually meet best practice.

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) <small>(QOF)</small>	82.8%	82.0%	79.3%	No statistical variation
Exception rate (number of exceptions).	22.7% (118)	16.7%	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) <small>(QOF)</small>	78.5%	80.9%	78.1%	No statistical variation
Exception rate (number of exceptions).	10.2% (53)	10.0%	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) <small>(QOF)</small>	78.8%	82.8%	81.3%	No statistical variation
Exception rate (number of exceptions).	18.3% (95)	12.7%	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) <small>(QOF)</small>	75.2%	76.1%	75.9%	No statistical variation
Exception rate (number of exceptions).	15.4% (78)	12.3%	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)	93.2%	91.2%	89.6%	No statistical variation
Exception rate (number of exceptions).	16.2% (37)	14.3%	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)	82.9%	84.0%	83.0%	No statistical variation
Exception rate (number of exceptions).	3.7% (44)	3.6%	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)	74.7%	90.9%	91.1%	Significant Variation (negative)
Exception rate (number of exceptions).	0.6% (1)	4.5%	5.9%	N/A

Any additional evidence or comments
<ul style="list-style-type: none"> Exception reporting allows practices to exclude eligible patients from indicators or an entire an entire clinical domain of the Quality and Outcomes Framework (QOF) when calculating success in achieving particular targets. It is expected that exceptions are kept as low as possible and the practice should understand the reasons for any exceptions. The practice prescribed anti-coagulation drug therapy opportunistically, the data indicated a significant negative variation for this outcome and although exceptions were low the total of patients identified (75%) indicated a number of patients were unaccounted for.

Families, children and young people

Population group rating: Good

Findings
<ul style="list-style-type: none"> The practice had met the minimum 90% for three of four childhood immunisation uptake indicators. The practice had not met the WHO based national target of 90% for one of four childhood immunisation uptake indicators. The practice contacted the parents or guardians of children due to have childhood immunisations as expected. Every child from 8 weeks old to preschool booster are sent specific appointments to attend for vaccinations and if they did not attend a total of six appointments were sent for that vaccination. Children with outstanding vaccinations were identified on the quarterly records search and again sent further appointments.

- An alert was placed on the records of all very overdue children so that the vaccine could be offered opportunistically when any other appointments were made.
- Parents could make an appointment for childhood vaccinations during any time that the practice was open.
- The children's influenza vaccination clinics were themed (Halloween / Christmas) to encourage the children to attend and ran until 7pm.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary, a monthly search was run and the parents/guardian was contacted.
- Young people could access services for sexual health and contraception and there was a specific young person's community clinic run at the practice.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Staff indicated they had completed protected learning courses with the CCG to maintain and develop appropriate skills to carry out reviews for this population group.
- Learning and training was self-directed. A formal training and learning plan was not in place. The provider had not developed and comprehensive training plan or curricula to ensure practice nurses and advanced nurse practitioners maintained and developed their skills.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	85	94	90.4%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	90	99	90.9%	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)	90	99	90.9%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles,	88	99	88.9%	Below 90% minimum

mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)				
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Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

The practice sent parents reminders and followed up children who missed appointments as expected. However, systems in place did not ensure a follow-up for all children who missed primary or secondary care appointments.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- There was follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified and action taken when this was not the case, although processes needed strengthening.

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). (Snapshot date: 01/07/2019 to 30/09/2019) (Public Health England)	68.9%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	69.2%	72.9%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	51.4%	57.5%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as	73.8%	71.0%	68.1%	N/A

occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) ^(PHE)				
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) ^(PHE)	49.1%	48.5%	53.8%	No statistical variation

Any additional evidence or comments

GPs and nurses had completed appropriate cervical screening training including a digital course. The practice was participating in local initiatives to increase the uptake of cervical screening, however, data indicated that at the time of the inspection visit sufficient initiative had not been taken and cervical screening uptake was significantly below target.

Appointments for smears were could be accessed during the practices opening hours including a late night on Tuesdays until 7.15pm.

The practice nurse was the CCG primary care nurse lead for cytology and attended screening programme meetings and since January 2020 had become involved in an initiative to enhance screening uptakes called "The Cervical Screening Text messaging task and finish group.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- All patients with a learning disability were offered an annual health check.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances and patients record was flagged and the patient was referred to a specialist service.

However,

- There was little evidence of actual coordination with local social services. This had been noted at clinical meetings and plans for improvement such as shared records had been discussed.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- There was a system for following up patients who failed to attend for administration of long-term medication. The practice nurses contacted these patients and mental health services as appropriate.
- 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.
- 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.
- Patients with poor mental health, including dementia, were referred to appropriate service.

However:

Staff had not received dementia training in the last 12 months.

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) <small>(QOF)</small>	92.0%	92.4%	89.4%	No statistical variation
Exception rate (number of exceptions).	4.3% (4)	13.5%	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) <small>(QOF)</small>	93.1%	92.1%	90.2%	No statistical variation
Exception rate (number of exceptions).	5.4% (5)	11.4%	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) <small>(QOF)</small>	83.6%	81.1%	83.6%	No statistical variation
Exception rate (number of exceptions).	3.2% (2)	7.2%	6.7%	N/A

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	555.1	546.4	539.2

Overall QOF score (as a percentage of maximum)	99.3%	97.8%	96.7%
Overall QOF exception reporting (all domains)	8.0%	6.9%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	No
Quality improvement activity was targeted at the areas where there were concerns.	No
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Partial

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

Clinical audits had not been completed in the previous two years. Searches had been run but the aim had not been a review of practice to see where formal changes and improvements could be made with the intention of repeating the search to check the effects and outcomes of the changes.

Any additional evidence or comments
The practice, in relation to palliative care, held a monthly multidisciplinary meeting which included the district nurses, community matron, MacMillan Nurse, representatives from St Helens carers; and the local hospital trusts admission avoidance team for palliative care patients.
The practice reviewed unplanned admissions for general patients however; patterns were not looked for to identify where processes could be improved to avoid admissions.

Effective staffing

The practice was unable 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.	Partial
The learning and development needs of staff were assessed.	Partial
The practice had a programme of learning and development.	No
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Not applicable

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.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	No
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial
Appraisals had been conducted with all reception and administration staff in the last year. Job descriptions for these staff had been reviewed and updated. The practice was in the process of reviewing mandatory and developmental training for operational staff. Formal mentoring and ongoing clinical supervision was not being provided to clinical and nursing staff. The practice had provided support and opportunities for GP and nurses to maintain their professional registration, however day to day formal mentoring, supervision and appraisals had not been organised.	

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment however, processes needed to be strengthened.

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)	Yes
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.	Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Partial
Patients received consistent, coordinated, person-centred care when they moved between services.	Partial
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A
Nurses and GPs stated that multidisciplinary meetings were held monthly to discuss vulnerable adult patients however, these were not documented. Discussions about vulnerable children were documented. The provider was signed up to an admittance avoidance scheme, to which patients who fitted the criteria could be referred and seen by an appropriate secondary care provider within 2 hours of referral. The practice had not yet signed up for shared care records which would enable out of hours and accident and emergency services to have limited access to patient records when these services were used. The practice was reliant on letters for communicating changes to GPs and systems to ensure these were actioned in a timely manner were not robust.	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
The nurses and advance nurse practitioners at the practice worked with patients to help them to live healthier lives through referrals to community based health promotion services such as the social prescriber; counselling service or smoking cessation.	

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 smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	96.2%	95.2%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.2% (5)	1.0%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Partial

The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes
The provider did not have systems in place to ensure care and treatment were in line with the Mental Capacity Act and Deprivation of Liberty safeguards.	

Caring

Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
The practice commissioned a counselling service which patients could access. The practice also referred patients to a social prescriber who could refer charitable and other social organisations such as debt counselling; keep fit classes or support groups.	

CQC comments cards	
Total comments cards received.	40
Number of CQC comments received which were positive about the service.	29
Number of comments cards received which were mixed about the service.	11
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Comment cards positive comments.	All comment cards stated the staff at the practice were caring, helpful and efficient, patients trusted the staff and patients were gratified by having same day access
Comment cards Negative comments	All the negative comments made concerned problems getting through to the practice by telephone.
Healthwatch St Helens	Healthwatch St Helens had not received any negative feedback about the practice.

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 had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	94.2%	90.2%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	90.4%	89.2%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	97.9%	95.7%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	83.3%	82.8%	82.9%	No statistical variation

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

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
The staff had access to language translation and interpretation services. Receptionists were able to signpost patients to other services if appointments were not available.	

Source	Feedback
Interviews with patients.	The appointments were as long as needed and patients were not rushed. The practice had been instrumental in helping patients to manage and improve long term conditions.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	94.1%	95.0%	93.4%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	92 patients 1%
How the practice supported carers (including young carers).	There was a carers information board. Staff understood that carers needed longer and more flexible appointment times and lengths.
How the practice supported recently bereaved patients.	Support for bereaved patients had been discussed at the practice meetings. Relatives were usually contacted after the funeral. The practice used to send sympathy card but this had not occurred recently. The plan was to resume sending a card and bereaved patients could be referred to the in-house counsellor.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Partial
There was a large reception desk, however, an exclusion zone for patients to wait behind was not in place.	

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	Not applicable
The practice ensured patients were informed how their records were stored and managed.	Not applicable
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Not applicable
Online consultations took place in appropriate environments to ensure confidentiality.	Not applicable
The practice advised patients on how to protect their online information.	Not applicable
No online services such as electronic consultation was used by the practice.	

Responsive

Rating: Requires Improvement

We rated Effective as **requires improvement** because:

- Patients did not have ready access to a complaints policy;
- The complaints policy provided inaccurate information;
- The provider did not have oversight of all complaints because informal comments and concerns were not logged.

These findings meant all population groups in responsive were rated **requires improvement**.

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

Practice Opening Times

Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 9pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available: Appointments are booked on the day from 8am throughout the day. The GPs; ANP and HCA work the late night.	
Monday	8am to 6.30pm
Tuesday	8am to 9pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm

National GP Survey results

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)	98.5%	95.4%	94.5%	Tending towards variation (positive)

Older people

Population group rating: Requires Improvement

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 and urgent appointments for those with enhanced needs and complex medical issues. The practice provided effective care coordination to enable older patients to access appropriate services.

People with long-term conditions

Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> Patients with multiple conditions had the option to have their needs reviewed in one appointment. The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services. The practice nurses and advanced nurse practitioners liaised regularly with the local district nursing team to discuss and manage the needs of patients with complex medical issues. Care and treatment for people with long-term conditions approaching the end of life was discussed with other services.

Families, children and young people

Population group rating: Requires Improvement

Findings

- Appointments were available outside school hours so 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 a high number of accident and emergency (A&E) attendances. Meeting notes we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

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 was open until 6.30pm on Monday, Thursday, Wednesday and Friday and 9pm each Tuesday. Pre-bookable appointments were available to all patients at additional locations within the area, as the practice was a member of a Primary Care Network.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed understood how to support patients with mental health needs and those patients living with dementia. However, staff had not completed dementia training.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- The practice also identified the need for a counsellor and independently commissioned (purchased) and provided this service for their patients.

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.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes
The practice stated appointments were never cancelled.	

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)	34.1%	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)	65.6%	63.3%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or	61.7%	61.9%	64.7%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)				
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)	79.8%	70.9%	73.6%	No statistical variation

Any additional evidence or comments

The practice was aware of the limitations of the telephone system and had installed an updated system with additional lines and a queuing system. The practice had also introduced telephone consultations.

Listening and learning from concerns and complaints

Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	Less than 10
Number of complaints we examined.	Less than 10
Number of complaints we examined that were satisfactorily handled in a timely way.	Less than 10
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	No
There was evidence that complaints were used to drive continuous improvement.	No
<ul style="list-style-type: none"> Information provided by the practice indicated the service had received a small number of complaints in 2019. Information such as posters and leaflets about how to raise a complaint was not available in the waiting room and patients had to request a complaint form from the receptionist. The complaints policy did not provide accurate and comprehensive information about how to make a complaint about National Health Service (NHS) care and treatment. There were no formal processes for recording and reviewing informal concerns and comments. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Discussed with the practice	Discussed during inspection and evidence indicated that complaints were fully investigated and discussed with some staff however, lessons learnt were not formalised.

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Well-led

Rating: Requires Improvement

We rated Well-led as **requires improvement** because:

- Leaders did not demonstrate a full understanding of the how to deliver high quality services throughout the practice.
- The practice was not supported by a clear vision and strategy.
- A comprehensive audit plan to review clinical and operational outcomes was not in place.
- Systems did not support learning from information provided to the service for example audits; incidents and complaints.
- Communication systems needed to improve.

Leadership capacity and capability

There was compassionate leadership at all levels however, leaders could not demonstrate 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.	Partial
They had identified the actions necessary to address these challenges.	No
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	No
The practice understood the challenges relating to where the practice was situated and the needs of the practice population and were aware of the outcomes that needed to improve for patients. The provider had not developed plans of action to bring about timely or sustained improvements in all the areas required. A leadership development plan was not in place for leaders and potential leaders.	

Vision and strategy

The practice had a clear vision but it was not supported by a 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.	Partial
There was a realistic strategy to achieve their priorities.	No
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial

Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	No
The practice had identified that a strategy which included business plans, risk assessments and a review of policies and procedures in place was required and had started developing these processes.	
The provider had not identified a vision and developed a strategy to support high quality care.	

Culture

The practice had a culture which drove high quality sustainable care, however processes in place did not support this.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Partial
The practice had access to a Freedom to Speak Up Guardian.	Partial
Staff had undertaken equality and diversity training.	No
A whistleblowing policy was in place however, staff were not aware of accessing the Freedom to Speak Up Guardian.	
The practice could not confirm whether the majority of staff had completed up-to-date equality and diversity training.	

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

Source	Feedback
Staff interviewed	<p>The senior partner is very accessible and staff felt able to make their views known. Staff identified that there had been a lot of changes to the clinical and management teams in recent months. There was an emphasis on treating patients and responding to immediate needs.</p> <p>There was protected time for learning and support to attend training courses and professional development meetings when requested.</p>

	<p>There was no quality assurance plan and staff reviewed their own standards informally.</p> <p>Staff were aware that appraisals and supervisions had been introduced but had not themselves received any formal supervision or mentoring.</p> <p>Staff confirmed concerns could be raised and gave examples of changes made due to concern raised although these had not been included in the incident reports recorded by the management team.</p>
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Governance arrangements

Roles, responsibilities and systems of accountability to support good governance and management needed to be strengthened.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Yes
<ul style="list-style-type: none"> Staff were aware of the lines of accountability at the practice. The practice did not have systems which included clear roles and responsibilities in relation to good governance and driving improvements for clinical, nursing or administrative staff, for example there was uncertainty about lead roles such as infection control lead; deputy safeguarding lead and lead for dealing with alerts sent to the practice. Records of clinical meetings indicated practitioners worked together to find solutions in response to specific problems. However, this did not happen in relation to ongoing governance and improvements in the service. 	

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	No
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Partial
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial

- A comprehensive assurance system was not in place however, the practice was in the process of reviewing governance systems and had identified that many were out-of-date or not-fit-for-purpose and action was being taken to make improvements.
- Staff were familiar with the major incident plan and this had been deployed on a few occasions over time. Staff were confident in describing the actions taken to keep the service running during an incident.
- The practice had made changes in response to feedback and considered the impact of such changes informally.
- Some risk assessments had been completed for example legionella and infection control. However, the systems had not ensured all risk assessments required by law had been completed and mitigated, for example fire safety; control of substances hazardous to health (Coshh) for items supplied by the practice and general health and safety assessments had not been completed.

Appropriate and accurate information

There was a demonstrated an ability to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
There were examples of the practice using data to drive improvements and change practice however, systems were not in place to ensure this was routine.	

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Any unusual access identified was followed up.	Yes

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes

Staff views were reflected in the planning and delivery of services.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<ul style="list-style-type: none"> • Staff reported that their views were listened too however, this was not formalised. • The practice was a part of a local primary care network and participated in meetings to discuss the services needed for the local population for example social prescribing. 	

Feedback from Patient Participation Group.

Feedback	
The Patient Participation Group indicated positive changes included:	
<ul style="list-style-type: none"> • there had been recent improvements to the telephone systems; • the GPs could be relied on to called back for telephone consultations as arranged and • the practice now used a preferred nominated pharmacist so that prescriptions could be sent direct to a pharmacist close to the patients address. 	

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation however, these needed to be strengthened.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
<ul style="list-style-type: none"> • The practice made changes as a result of learning from feedback from patients; data; observations and incidents however, the action taken was not always formalised to enable the effectiveness of changes to be monitored. • The reasons for changes was not always fully explained and learning was not always shared. • The practice participated in projects and pilots initiated at a local or national level. 	

Examples of continuous learning and improvement
The practice participated in a local review of patients with chronic obstructive pulmonary disease (COPD). This was in collaboration with a local specialist hospital. Patients had their medicines changed as a result of their involvement in the pilot.

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 rule 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 considered 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 considering the types of people who will be receiving that treatment.