

Care Quality Commission

Inspection Evidence Table

Castlecroft Medical Practice (1-570813757)

Inspection date: 12 August 2021

Date of data download: 30 July 2021

Overall rating: Good

At our previous inspection in September 2019 we rated the practice as Requires Improvement overall. This was because we identified issues related to the management of medicines and equipment and the lack of general oversight of processes and governance arrangements. At this inspection we found that these areas had been addressed and the practice was rated as good overall.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe

Rating: Good

At our previous inspection in September 2019 we rated the practice as requires improvement for providing safe services because:

- Effective systems were not in place to ensure medicines and equipment were secure and safe to be used.
- Safety alerts related to patients care and treatment were not received at the practice.
- There was a lack of documented evidence to demonstrate learning from incidents and complaints.

At this inspection we found the practice had adequately addressed all the issues previously raised and we rated the practice as good for providing safe services.

Safety systems and processes

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

Safeguarding	Y/N/Partial
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.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had a nominated safeguarding lead and staff we spoke with were clear as to who this was. • Staff had access to safeguarding policies and procedures and relevant contacts should they need to make a referral to the appropriate authority. • Clinical staff had a good understanding of safeguarding and were able to provide examples of concerns that had been effectively followed up. • Alerts were used on the clinical system to ensure staff were aware of patients who may be at risk. • Training records showed all staff had received and were up to date with safeguarding training (children and adults) to an appropriate level for their role. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • At our previous inspection in September 2019 we found that staff did not all have personalised job descriptions. Records we reviewed at this inspection showed job descriptions had been developed based on staff roles. • The practice had comprehensive staff records with appropriate recruitment checks and immunisation histories in place. • We saw checks relating to clinical staff registration with their professional bodies had been undertaken. 	

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: December 2020	Yes
There was a record of equipment calibration. Date of last calibration: December 2020	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
A fire risk assessment had been completed. Date of completion: June 2021	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Control of Substances Hazardous to Health (COSHH) risk assessments had been completed for substances held at the practice. All staff were up to date with their fire safety training and additional training had been undertaken by the practice's fire marshals. The practice had carried out regular fire drills so that staff knew what to do. A log of drills carried out had been maintained. Records showed fire equipment had been checked in the last 12 months and fire alarms tested weekly. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We saw that risk assessments related to the premises and health and safety had been reviewed and put in place. Records we examined showed that checks related to the maintenance of the premises had been completed. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit:	
The practice had acted on any issues identified in infection prevention and control audits.	Yes
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.	
Explanation of any answers and additional evidence: <ul style="list-style-type: none">At the last inspection in September 2019 we found that the practice had not addressed all the issues raised at the last infection control audit. At this inspection action had been taken to address issues identified. For example, a cleaning rota was put in place for nurse clinical rooms. Risk assessments were completed to mitigate the risk of any changes which were not feasible due to the design of the practice.One of the practice nurses was the designated lead for infection prevention and control.All staff were up to date with infection prevention and control training.Infection prevention control procedures had been reviewed and implemented in line with national and local guidance to minimise the risk of COVID-19 infections.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">At the last inspection we found that not all waiting rooms could be viewed by staff, which meant that staff would not be aware if a patient's health was deteriorating. At this inspection we found that CCTV cameras had been fitted and notices displayed made patients aware that the cameras were in place.Our findings at the last inspection also identified that clinic rooms were not locked and could easily be accessed by patients or other visitors. At this inspection we saw that clinic rooms were locked when they were empty.The practice carried out emergency simulation training sessions that involved using basic life support techniques within the clinical area. The feedback from staff was positive and areas for improvement were noted. This included the implementation of a flow chart or checklist for reception staff to follow in the event of a medical emergency, replacing the emergency bag with a trolley and to continue with regular simulation sessions in different areas of the practice.	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N/A
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Summarising of new patient records was undertaken by clinical staff.• Our review of the practice workflow found that test results were managed in a timely way.	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.70	0.69	0.69	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2020 to 30/06/2021) (NHSBSA)	10.3%	6.8%	10.0%	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 (01/01/2021 to 30/06/2021) (NHSBSA)	5.65	5.17	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	114.5‰	132.0‰	126.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.77	0.69	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	3.4‰	8.6‰	6.7‰	Variation (positive)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the last inspection in September 2019 we found: <ul style="list-style-type: none"> A number of out of date medicines and equipment in clinical rooms. Emergency medicines were stored in different areas within the practice and not all staff were aware of where the nearest emergency equipment or medicines were located. Emergency kits contained medicines, needles and syringes that had expired. There were gaps in temperature monitoring of all medicine fridges and some fridges did not contain a secondary thermometer. At this inspection we found that the issues identified above had been appropriately addressed. The systems for the safe management of medicines had been reviewed and procedures updated. For example, records we examined showed emergency medicines held at the practice were checked to ensure the medicines were in date and fit for use. The practice's medicine policy outlined that patients returned medicines would not be accepted at the practice and patients would be directed to return these to the pharmacy. Where recommended emergency medicines were not routinely held, the practice had undertaken appropriate risk assessments. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> Prescribing data showed the practice to be in line with or showing positive variation when compared to other practices locally and nationally. We reviewed records for patients prescribed two different anti-inflammatory medicines that required regular monitoring. We found that all patients prescribed these medicines were appropriately monitored. We reviewed a sample of records for patients prescribed three high risk medicines requiring routine blood tests and monitoring and found that appropriate arrangements and routine monitoring were in place for two of the three medicines. For one of the high risk medicines used to control high blood pressure, we found that patients had not been routinely monitored in line with guidance. Five records randomly examined showed monitoring was overdue. The last recorded blood pressure check suggested no evidence of harm for all five patients. However, there was no record of a recent blood test. The practice followed this up immediately and identified all patients prescribed these medicines and made arrangements for relevant follow up and tests to be completed. Practice staff explained that some patients had been reluctant to attend due to the pandemic. Three of the records we examined showed patients had been invited for tests but failed to attend. We saw prescription stationery was appropriately stored and monitored. There were appropriate arrangements in place for the management of vaccines and for maintaining the cold chain. We saw fridge temperatures were routinely monitored and vaccines reviewed at random were in date and stored appropriately. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	6
Number of events that required action:	2
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice used a practice management platform for documenting incidents and learning events and all staff we spoke with were aware of this. We saw from practice meetings that incidents were discussed as a standard agenda item and learning was shared among the team. 	

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

Event	Specific action taken
Misplaced patient letters – letters intended to be collected by patients were not left in the correct place resulting in them being collected and sent through the hospital internal post system in error.	<ul style="list-style-type: none"> Investigation carried out to determine what happened and why. The patients involved were contacted and the situation discussed. An apology was given and copies of the letters offered so that patients were aware of the contents of the letters sent to the hospital by mistake. Discussions were held with the staff involved, which concluded that the error occurred due to miscommunication. To prevent this happening again, practice staff considered the labelling of correspondence to confirm destination and how to be progressed.
Vaccine fridge failure	<ul style="list-style-type: none"> One of the medicine fridges at the practice was found to have developed a fault over the weekend. Due to the unknown length of time that the fridge had not been working and no fridge thermometer data logger to give an indication of the stability of the medicines the practice made the decision to destroy the medicines. Engineer called and recommendations made, this included running the fridge empty for one month to ensure it was working properly. Changes made included – checking medicine fridges early on Monday mornings particularly those in rooms not always occupied.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was a lead GP for the management of safety alerts. All clinical staff were signed up to receive safety alerts directly from the Medicines and Healthcare Products Regulatory Agency (MHRA). Our review of clinical records identified that appropriate action had been taken in response to alerts from MHRA. 	

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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Our review of the practice clinical system identified appropriate management of patients care and treatment. Staff told us that they had monthly practice meetings where they discussed current guidance. For example, staff told us how they had responded to changing guidance during the pandemic and had undertaken training related to remote consultations and the administration of the new vaccines. 	

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> 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. Clinical staff followed up on older patients discharged from hospital and ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. The practice carried out structured annual medicines reviews for older patients. Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: **Good**

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- 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.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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. (01/04/2019 to 31/03/2020) (QOF)	70.2%	75.5%	76.6%	No statistical variation
PCA* rate (number of PCAs).	16.2% (123)	6.7%	12.3%	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 (01/04/2019 to 31/03/2020) (QOF)	84.8%	88.4%	89.4%	No statistical variation
PCA rate (number of PCAs).	25.3% (49)	8.6%	12.7%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	82.5%	80.6%	82.0%	No statistical variation
PCA* rate (number of PCAs).	6.3% (17)	3.9%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	67.8%	64.0%	66.9%	No statistical variation
PCA rate (number of PCAs).	17.0% (100)	11.8%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	69.3%	70.5%	72.4%	No statistical variation
PCA rate (number of PCAs).	4.7% (70)	5.6%	7.1%	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 (01/04/2019 to 31/03/2020) <small>(QOF)</small>	93.0%	91.9%	91.8%	No statistical variation
PCA rate (number of PCAs).	3.2% (10)	3.7%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	72.7%	73.0%	75.9%	No statistical variation
PCA rate (number of PCAs).	10.9% (64)	8.4%	10.4%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments

- Reported outcomes for the management of patients with long term conditions were in line with local and national averages.

Findings

- The practice had met the minimum 90% for four of five childhood immunisation uptake indicators. The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for one of five childhood immunisation uptake indicators. The practice was slightly below the 90% minimum target for the percentage of children aged five who had received immunisation for measles, mumps and rubella (two doses of MMR).
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- 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.
- 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.
- Young people could access services for sexual health and contraception.
- 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 immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	112	116	96.6%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	110	119	92.4%	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) (01/04/2019 to 31/03/2020) (NHS England)	110	119	92.4%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	110	119	92.4%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	113	128	88.3%	Below 90% minimum

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

Any additional evidence or comments

- The uptake of childhood immunisation of children aged five showed this was under the 90% minimum target. Although a slight decrease, published data showed there had been a fall in uptake between 2019 and 2020. The provider was aware of this and had identified that the COVID-19 pandemic was one of the reasons for the decrease. The practice nurses had plans in place to address this.

Working age people (including those recently retired and students)

Population group rating: Good

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. 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 medicines without the need to attend the surgery.

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: 31/03/2021) <small>(Public Health England)</small>	77.0%	N/A	80% Target	Met the 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	75.6%	65.7%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	65.6%	54.9%	63.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	43.6%	48.0%	54.2%	No statistical variation
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 (Snapshot date: 31/03/2021)	79.7%	84.9%	N/A	N/A

Any additional evidence or comments

- The practice was below the England average of the Public Health England (PHE) target of 80% however, was above the England comparison uptake target of 70% at the snapshot date of 31 March 2021. The practice attributed this decline to the suspension of cervical cancer screening in the early months of the COVID-19 pandemic.
- Trend data overtime showed that the practice uptake over a period of five years had been maintained consistently above 70%.
- Data we looked at for the uptake of breast and bowel cancer screening showed a significant increase on the previous year and remained higher than the England average.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- 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 reviewed young patients at local residential homes.

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.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- 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 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 (01/04/2019 to 31/03/2020) (QOF)	83.8%	75.1%	85.4%	No statistical variation
PCA* rate (number of PCAs).	9.8% (4)	15.8%	16.6%	PCA rate below threshold
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	77.6%	66.7%	81.4%	No statistical variation
PCA rate (number of PCAs).	7.8% (9)	9.8%	8.0%	PCA rate below threshold

*PCA:.. Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care and treatment provided.

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	541.6	533.9
Overall QOF score (as a percentage of maximum)	96.9%	95.5%
Overall QOF PCA reporting (all domains)	5%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

<ul style="list-style-type: none"> One of the audits completed at the practice looked at the type of contraception prescribed for women taking a specific anti-epileptic medicine. The audit was carried out because recent guidance showed that using a combined hormonal contraception with this anti-epileptic medicine could lead to the reduced control of seizures. A search of the practice clinical records identified patients prescribed the anti-epileptic medicine and a review of their treatment was carried out. None of the patients were identified as taking contraceptives that reduced the effect of their anti-epileptic medicine. The clinicians used the opportunity to discuss the concerns of being prescribed these medicines at the same time with the patients.
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Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Following the inspection in September 2019 the practice had introduced new appraisal forms. Due to the COVID-19 pandemic the decision was made in agreement with the practice staff to postpone appraisal meetings during 2020. Supervision of staff continued and a schedule put in place to complete all staff appraisals by the 30 September 2021. Examples of staff appraisals completed were shared with us on the day of this inspection site visit.	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">We saw evidence of regular staff meetings to ensure staff were kept up to date with guidance and best practice during the COVID-19 pandemic.The practice shared relevant information with out of hours services to support continuity of care.	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had access to a social prescriber who was able to provide support to patients and signpost them to relevant services in the community.• Patients had access to information related to their health and wellbeing at the practice and on the practice website.• Staff at the practice helped to support the local COVID-19 vaccine programme. Home visits were made to patients who were assessed as vulnerable and their health needs prevented them from attending the practice or designated hub sites.	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Practice staff were aware of legislation and guidance when considering consent and put this into practice when providing care and treatment to patients.• Our clinical searches identified that DNACPR decisions made were appropriate and clearly recorded.	

Well-led

Rating: Good

Leadership capacity and capability

At our previous inspection in September 2019 we rated the practice as requires improvement for providing well led services because:

- There was a lack of management oversight of issues and risks within the practice.
- It was not clear which practice staff were responsible for what roles.
- Effective governance arrangements were not in place to mitigate risks and ensure patients were kept safe.

At this inspection we found the practice had adequately addressed all the issues previously raised and we rated the practice as good for providing well led services.

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The provider and management team with the inclusion of all the staff working at the practice had developed a detailed business and development plan. The document focused on the immediate action needed to plan and ensure a working foundation for the future of the practice. The document was described as a living document which would be reviewed over the years as progress is made.• The development of the practice included areas to improve services for patients. For example, the practice planned to work with local colleagues and services to ensure patients had continuous access to care and treatment during the COVID-19 pandemic. There were plans to increase the diversity of staff within the practice for example, employing clinical pharmacists and supporting existing staff to develop their skills and advance professionally.	

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.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes

Explanation of any answers and additional evidence:

- The management team had written a business plan which clearly set out their vision and values for the practice. The plan had been developed with the practice staff.
- Practice staff were able to share with us the vision and values of the practice. This included the provision of patient focused quality care in a professional environment.
- The practice vision considered the impact the changing external environment and national directives could have going forward.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Following our last inspection in September 2019, the practice management team had reviewed the processes in place for managing complaints and significant events. We found that new systems which included new incident forms had been put in place. Records we examined showed that they were more comprehensive and included details of the investigation and analysis of incidents and concerns raised. • We saw evidence that patients' complaints were acknowledged and where things went wrong patients received an apology and were informed of the outcome and action to be taken. • Staff we spoke with said they felt supported to raise and discuss any issues or concerns. • Training records showed that staff had completed Equality and Diversity Training. 	

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

Source	Feedback
Staff Discussions	Staff told us that they were supported by the management team and could approach any of the leadership team, which included clinicians if they had any concerns.

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.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> At our inspection in September 2019 we found that there was a lack of oversight of governance arrangements within the practice. Practice staff were not all clear about who held individual roles and responsibilities. At this inspection we found that improvements had been made to the operation, policies and administration processes within the practice. Staff we spoke with were clear about their individual roles and were also aware of the lead roles held by other staff. For example, staff could tell us who the leads were for safeguarding and infection control. Regular staff and governance meetings were held sometimes weekly to ensure important information and COVID-19 updates were shared in a timely way. 	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> At the inspection in September 2019 we found that there was a lack of management oversight of risks identified. These included practice staff not acting on actions identified in risk assessments in a timely manner, security of unlocked clinical rooms and expired medicines and equipment. At this inspection we found that these issues had been addressed. This included: <ul style="list-style-type: none"> The review of policies and procedures, to ensure appropriate processes were in place for checking medicines and equipment stocked at the practice. The completion of risk assessments and the implementation of arrangements for managing the safety of the premises. 	

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Home visits were available to the practice's most vulnerable patients. • Through arrangements with the practice primary care network, patients were able to access additional video/teleconferencing consultations in the evenings and at weekends. • Practice staff advised us that they actively monitored two week waits to ensure there were no delays. • Practice staff received additional infection control training that covered practices and procedures that had to be followed during the COVID-19 period. • There were arrangements in place for staff to work remotely to support the continuity of services, if needed. 	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • At our previous inspection in September 2019 we found there were gaps in the management of complaints, significant events and risk assessments. Records checked at that time showed the information available was not used to inform learning and support decision making. At this inspection we found that the availability and quality of documentation had significantly improved. • Our remote searches of the practice clinical system did not identify any significant concerns related to the use of data and information to support decisions specific to patient care and treatment. 	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had access to approved software to support remote consultations with patients. Practice staff had received training to support them through the COVID-19 pandemic. This included using the new software and equipment to support remote consultations and related legislation and guidance that needed to be followed in respect of privacy and confidentiality. 	

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> At the last inspection we found there was a lack of information to demonstrate learning and improvement. At this inspection we found that the practice had improved and staff were involved in making changes and learning was shared with staff. Systems had been introduced to enable staff to discuss incidents and complaints that had occurred. The practice learnt from incidents and complaints. Practice staff were encouraged to develop their skills to maintain competences and professional development was supported. For example, one of the practice nurses was being supported to complete advanced nurse practitioner training. The practice worked with other practices within their primary care network group based in Wolverhampton, which provided peer support and opportunities for learning and improvement. The GPs and practice nurses attended regular online peer group meetings. The practice website had been updated to provide appropriate and up to date information and education for patients. 	

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.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- % = per thousand.