

Inspection Evidence Table

The Weavers Practice (1-7818930875)

Inspection Date: 17 August 2023

Date of data download: 08/08/2023

Overall rating: Good

At our previous inspection on 14 July 2022 the practice was rated requires improvement overall. The rating for key questions safe, effective and well led services was requires improvement and caring and responsive services were rated as good. We issued requirement notices for breach of regulation 12(1) Safe care and treatment and for regulation 17(1) Good governance.

This inspection was to review the practice’s progress in implementing improvements to ensure compliance with the regulations.

This inspection identified improvement in all the areas previously identified as requiring improvement and the service is now rated good.

Safe Rating: Good

At our previous inspection in July 2022 we found some recruitment records were incomplete, infection prevention and control audits were not in place, medicine reviews were not completed comprehensively and prescribing practices for some medicines required review and action. This inspection identified that all these areas had been addressed

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y

The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
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.	Y
<p>Explanation of any answers and additional evidence:</p> <p>One GP partner was the lead for all safeguarding matters, and they were supported by a deputy lead who was also one of the practice's partners.</p> <p>The safeguarding lead attended local area safeguarding meetings provided by the local integrated care board (ICB). A dedicated email address was in place so that any safeguarding issues or concerns sent to the practice were responded to on the same day.</p> <p>The practice had regular contact and meetings as needed with health visitors to discuss children and families who had not attended for vaccinations or other appointments.</p> <p>The system to record staff training had improved since our previous inspection and records for clinical staff showed that they were all trained to the appropriate safeguarding level. The clinical staff we spoke with demonstrated a clear understanding of safeguarding and what action to take should they have a concern about a child or adult.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection, we found not all recruitment information required by legislation was available. At this inspection, the sample of 3 newer staff files we reviewed contained the correct information. For example, they contained evidence of photographic identification; information regarding immunisation status including hepatitis B and workplace references that provided evidence of conduct in previous employment.</p> <p>Systems to monitor clinical registration was established and all staff had a DBS check in place.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y

Date of last assessment: Various dates recorded for various aspects of health and safety	Y
There was a fire procedure.	Y
Date of fire risk assessment: 19 January 2023	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The surgery at Rishton was an older building that provided clinical consultations on the ground floor. This GP practice location was owned and managed by the GPs. The health and safety checks, maintenance of the building and equipment, and cleaning of the facilities was the responsibility of the GP partnership. Some refurbishments had been undertaken with further redecoration planned.</p> <p>The GP practice at Great Harwood, was the branch location and was located within a modern health centre, where the landlords took responsibility for workplace health and safety, building maintenance and cleaning. The practice manager had oversight of all the cleaning and building maintenance records.</p> <p>Records we reviewed included fire safety checks, legionella and maintenance records for both GP surgeries and these were all up to date.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: July 2023	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Comprehensive infection prevention and control (IPC) policies were available and these were supported by appropriate protocols. Each GP surgery had a designated IPC lead, and oversight was provided by a GP partner. At our inspection in July 2022 IPC audits had not been conducted. IPC audits had been undertaken at this inspection in August 2022 and July 2023. The audits recorded areas requiring action and these were addressed. For example the floor covering in the reception area at the Rishton surgery had been replaced to provide a more hygienic floor covering.</p> <p>The practice manager also conducted periodic spot checks on each area and consultation room. Records of these checks were available.</p>	

The staff training matrix identified that staff had received appropriate training online and staff we spoke with had a good understanding of maintaining and promoting infection prevention and control.

Both GP surgeries were clean, tidy and uncluttered. Privacy curtains and clinical waste storage, including sharps containers were appropriately managed. Access to personal protective clothing and hand gel was good.

Risks to patients

There were 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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
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.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y

Explanation of any answers and additional evidence:

Since our previous inspection, the management team had continued to harmonise policy, procedure and practices across both locations so that all staff could provide cover in the event of a sudden or unexpected absence. There was a mix of staff who worked across both GP locations and those who were permanently based at one location.

Reception staff feedback indicated that they felt understaffed due to staff absence and the recent departure of a staff member. Recruitment to this vacant post was underway.

Refresher training in care navigation had been provided to reception staff and this supported them in directing patients to the appropriate clinicians for their needs. The practice had a number of different clinical staff (Additional Roles Reimbursement Scheme (ARRS)). ARRS enables Primary Care Networks to recruit additional clinical and social care roles to help increase patient access to the right care and treatment.

Staff recruitment records contained comprehensive role related and health and safety induction records. Since the previous inspection staff induction training records were available and staff told us their induction included on the job training with support, mandatory eLearning and health and safety.

The practice had oxygen and an automated external defibrillator (AED) with appropriate emergency medicines to respond to a medical emergency at both GP surgeries. At the

Rishton GP surgery the emergency medicines were located in a locked cupboard and the oxygen and defibrillator was kept securely in the reception area. Regular checks were undertaken on all the emergency medicines and equipment.

At the Great Harwood GP surgery, the AED was shared between 2 other GP practices. We reviewed this location and noted that regular checks were recorded to ensure the AED was fully charged and safe to use. The AED was accessible to the Great Harwood GP staff team if they needed it. Emergency medicines were stored in a locked grab box within a secure accessible location within the Great Harwood GP 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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence:	
Our review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients.	

Appropriate and safe use of medicines

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

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) <small>(NHSBSA)</small>	1.20	0.97	0.91	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and	6.1%	5.3%	7.8%	No statistical variation

quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2022 to 31/03/2023) (NHSBSA)				
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 (01/10/2022 to 31/03/2023) (NHSBSA)	4.88	5.17	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	230.8‰	176.2‰	129.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.99	0.40	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	9.9‰	7.0‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Y
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.	Y
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.	Y

The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
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.	NA
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
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.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>The GP and practice management team worked collaboratively with the ICB medicine optimisation team. The practice's prescribing rates of different types of medicines were reviewed and strategies discussed to try to reduce prescribing of some medicines in accordance with changing best practice guidance. Monitoring of prescribing practice for all clinicians including GPs and non-medical prescribers was undertaken. For example, an antibiotic audit was available and cycles of this audit were available for July, November 2022, and July 2023.</p> <p>Since July 2022, the GP practice along with the PCN team had recruited and deployed a range of 'Additional Roles Reimbursement Scheme' (ARRS) staff. This included access to a clinical pharmacist to support them with patient medicine reviews.</p> <p>At our inspection in July 2022 searches of the patient record system were undertaken by a CQC GP specialist advisor, we found some areas of clinical governance required improvement. This inspection, our clinical searches identified that all these areas had been addressed. These included for example:</p> <ul style="list-style-type: none"> At the previous inspection, we noted 14 patients were prescribed a combination of Clopidogrel (used to prevent blood platelets sticking together) and Omeprazole (used to minimise stomach upsets). National clinical guidance produced by the National Institute for Health and Care Excellence (NICE) outlines that these medicines should not, in most cases be prescribed together as they reduce the effectiveness of Clopidogrel. This inspection identified 13 of these cases had been addressed and the 1 remaining patient who was prescribed these medicines was under review. 	

- A range of clinical searches were established by the practice to alert clinicians to the specific blood test and monitoring required for each prescribed medicine where necessary. The clinical team had extended the ranges of the clinical searches so that alerts were flagged for patients prescribed a diuretic (water tablet) known as a potassium sparing diuretic.
- Action had been taken so that patients prescribed a blood thinning medicine (Warfarin) had a recorded audit trail within their notes to evidence that these had been reviewed before the issuing of a prescription. A two cycle clinical (September 2022 and July 2023) audit had been undertaken to monitor the downloading and recording of blood test results within the patient record. Audit results for the second cycle showed improvements from 47% to 85% of patients having their blood results logged in their notes. A third audit cycle was scheduled for later this year.
- The quality and content of medicine reviews had improved and a record was available of what medicines had been reviewed.

We did note at this inspection, that some patients did not have an identified date documented on their prescriptions for medicines they were prescribed once per week. We raised this with the provider during the inspection and they told us they would rectify this.

Our review of the practice's achievements for the year to March 2024 found that monitoring of patients' bloods and health checks for patients prescribed a range of different medicines were up to date.

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.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	8
Number of events that required action:	8
Explanation of any answers and additional evidence:	
The practice team we spoke with demonstrated an understanding of what a significant event was, how these were logged, assessed and how learning was identified and shared.	

Regular clinical meetings were undertaken and the partners held a weekly management meeting where incidents and complaints were reviewed. Minutes of meetings were available

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

Event	Specific action taken
Delayed referral.	Once it was identified that a referral had not been completed, this was undertaken. The system to ensure referrals were processed and monitored was reviewed by the team and found to be effective. The induction information packs for trainee GPs and locum GPs was updated to ensure a consistent approach was taken when generating a referral.
Inaccurate recording following receipt of maternity discharge information.	The practice reviewed how they identified and recorded maternal hospital discharge information. A safety netting process was introduced that required a senior administrator to double check the information being logged in a patient record. The local hospital was contacted and informed of the issue regarding their communication and documentation. However, their response was the this could not be changed.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice worked closely with the clinical pharmacists who supported the practice in reviewing and responding to patient safety alerts. Regular searches were undertaken for prescribed medicine combinations identified in historical safety alerts. A spreadsheet of these alerts was maintained and a copy provided to us.</p> <p>In response to a recent alert regarding a diabetes medicine and potential vitamin B12 deficiency the practice reviewed their patients prescribed this medicine and identified 15 patients. Action had been taken as appropriate for each patient. The team also incorporated the blood test for vitamin B12 to the standard blood tests undertaken for those prescribed this diabetic medicine.</p>	

Effective

Rating: Good

In our inspection in July 2022, we identified training records, including induction training records, were incomplete and staff appraisals had not been undertaken. Published childhood immunisation uptake figures were also significantly below target levels. All these areas had improved at this inspection, staffing records and induction records were available and the published childhood immunisation data showed an achievement of over 90% for each indicator.

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y

Effective care for the practice population

Findings

The practice employed a nurse practitioner whose role was specifically to support older patients, who were assessed as frail and or vulnerable. The nurse visited patients who were housebound or who struggled to get to the GP surgeries and undertook a full review and assessment of their physical, mental, and social needs. Close liaison with the GPs was in place to ensure the right care and treatment was provided.

The practice had access to two community support teams including the Acute Visiting Team and the Integrated Neighbourhood Team (INT); both services could provide rapid assessment and support to patients. The nurse practitioner had established strong collaborative working relationships with the INT and was able to provide examples of how a bespoke person-centred care package was provided to vulnerable patients.

Patients living in care homes had the support of the primary care network (PCN) care home nursing team. This team provided regular review and quick assessment if an acute need was identified.

The PCN employed a number of ARRS including a first contact physiotherapist, a mental health practitioner, an Associate Psychological Practitioner (APP), a Trainee Associate Psychological Practitioner (TAPPS) and a clinical pharmacist. These distinct roles enabled the practice to offer local bespoke care and treatment to their patient population.

Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group in accordance with national guidance and the availability of the vaccines.

Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

All patients with a learning disability were offered an annual health check. These were undertaken by the nurse practitioner.

Patients requiring palliative care were monitored. The nurse practitioner was developing a protocol for the palliative care approach for patients with implanted defibrillator (ICD) to prevent unnecessary cardiac shocks and discomfort when the patient was at the end of their life.

Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

As part of our adapted inspection methodology, searches of the patient record system were undertaken by a CQC GP specialist advisor. This included reviewing a sample of patient records with different long-term health conditions. We noted that care and treatment plans

for patients were completed comprehensively. Our examination of the patient record system identified that timely progress in ensuring patients received these reviews had been made.

We observed at our previous inspection that patients who were potentially diabetic did not always receive the required monitoring to confirm that diagnosis. At this inspection we found that this had been actioned and those who were assessed as borderline diabetic received regular monitoring to confirm the diagnosis and so enable appropriate care and treatment to be provided.

Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. Staff who were responsible for reviews of patients with long-term conditions had received specific training.

The practice nursing team were proactive in trying to support newly diagnosed diabetic patients with as much information as possible to enable them to understand their condition and how to self-manage this. The first appointment following diagnosis of type 2 diabetes was 45 minutes in length where the disease and its management was discussed with the patient. One of the practice nurses had pulled together an information pack to give to the patient and this included a range of leaflets offering guidance and support.

The pack included:

- 'A guide to Type 2 Diabetes';
- 'Looking after your feet'.
- 'Exercises standing or sitting'.
- 'Eating Well' with meal ideas and
- information on 'Empower', a local diabetes education course.
- Another practice nurse had created a large word search puzzle for patients to find 49 words of foods that could affect blood sugar levels.

GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

Adults with newly diagnosed cardio-vascular disease were offered statins. Patients with suspected hypertension were offered ambulatory blood pressure monitoring. Patients with COPD were offered rescue packs if this was appropriate.

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) (01/04/2021 to 31/03/2022) <small>(UKHSA COVER team)</small>	86	91	94.5%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	79	84	94.0%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	81	84	96.4%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	80	84	95.2%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	97	105	92.4%	Met 90% minimum

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

Any additional evidence or comments
Immunisation data available at the last inspection was significantly lower (between 5 and 12% achievement). Data available for this inspection as detailed above shows improved performance, with all indicators above the minimum 90% and two indicators above the World Health Organisation's (WHO) target of 95%.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	64.4%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	67.6%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened	71.4%	N/A	80.0%	Below 80% target

adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (3/31/2023 to 3/31/2023) (UKHSA)				
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	66.7%	55.4%	54.9%	No statistical variation

Any additional evidence or comments

The practice encouraged patients to attend for cervical screening and implemented a reminder/recall system for those who did not make an appointment. Screening was also offered opportunistically. Patients could also access appointments for cervical screening at the extended access service in the evening and weekends.

One of the practice nurses we spoke with confirmed that since the previous inspection they had received training to undertake smear checks. They confirmed that they were doing well with uptake for smear in this current year. The data above for achievement in cervical cancer screening showed a slight improvement on the data snapshot from the previous year.

Data published by NHS Digital showed the GP practice was one of 16 practices out of 48 in East Lancs ICB to improve their performance in the last quarter of 2022.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:	
<p>A range of clinical audits were available for us to review. These included a three cycle antibiotic quality improvement audit, audits and report for prescribing metformin and checks on Vitamin b12 levels, a two cycle audit for the recording of patient blood results within the patient record for those prescribed Warfarin medicine, an audit of patients with a 'do not attempt cardiopulmonary resuscitation' (DNACPR) agreement to ensure review dates were not missed.</p>	

Non-clinical audits included infection prevention and control (IPC) audits, environmental spot checks and the practice was on a second cycle of a 'Plan Do Study Act (PDSA) audit/action plan on improving patient access to care and treatment.

Effective staffing

The practice was able 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.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in July 2022, the staff training matrix was not fully up to date and staff appraisals were behind the provider's schedule. At this inspection, these areas had been addressed.</p> <p>A comprehensive training record was available and our interviews with staff confirmed they were up to date with all mandatory training. The practice nurse we spoke with told us they were supported with their clinical training and development for primary care. The ICB had recently re-introduced protected learning time for one afternoon each month and this time was being used to attend training sessions and review the service provided.</p> <p>The reception staff team told us that due to staffing issues they frequently were not offered the same opportunities to attend team meetings and had to fit training into their schedule. The practice manager was aware of these staff concerns and was seeking ways to improve communication strategies and access to reception team meetings within the working day.</p> <p>We reviewed staff appraisals and found that they contained personal development objectives. Staff we spoke with confirmed that they found them useful.</p> <p>The two GPs partners were both GP trainers and monitored the consultation records of their trainees. The nurse practitioner (NP) worked in close liaison with the GPs when discussing the care and treatment of patients and one GP confirmed they reviewed a sample of</p>	

consultation records on a regular basis. A formal system to record this monitoring of consultation records for all clinicians working in advanced roles was being rolled out.

Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

Helping patients to live healthier lives.

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers, as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y

Explanation of any answers and additional evidence

We examined 5 patient's DNACPR records. The patient records detailed a full discussion with the patient and their family or carer. Their wishes with regards the DNACPR were respected. The practice used the 'Electronic Palliative Care Coordination System' (EPaCCS) to provide patients in the last year of life with an electronic co-ordinated care record to ensure coordination of care and communication between health and social care professionals involved in the end of life care of patients.

The practice had also audited all their patients with a DNACPR record coded within the patient notes. As a result of the audit a practice wide protocol was established to ensure that the quality of recording of DNACPR was of a good standard. Monthly searches were undertaken to ensure these were reviewed appropriately.

Responsive

Rating: Good

The practice team worked closely with the PCN to implement strategies to improve patient access to services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs

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

Practice Opening Times

Day	Time
Opening times: Both main and branch location	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available: Throughout the day Monday to Friday with a range of clinicians including ARRS.	
Extended access appointments were available from the GP federation from four hub sites located across the East Lancs community. Appointments were available from 6.30pm until 8pm Monday and Friday, and at weekends. These included face to face and telephone consultations with GPs, practice nurses, health care assistants and phlebotomists.	

Further information about how the practice is responding to the needs of their population

The practice team worked within the primary care network (PCN) to support community provision of healthcare initiatives. These healthcare initiatives enabled the practice to offer a diverse local service to their patients.

The practice employed a community-based nurse practitioner who provided a personalised service to older frail and housebound patients, patients with learning disability and other vulnerable groups.

Patients living in the community were supported with rapid response teams if they developed an acute illness.

Patients living in care homes had access to regular visits by a care home nursing team.

Urgent appointments for those with enhanced needs and complex medical issues were available.

Appointments for babies and young children were prioritised.

The practice was part of the GP federation and was able to offer patients extended access appointment after 6.30pm until 8pm Monday and Friday and access to telephone consultation on Saturday mornings.

People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and asylum seekers.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Explanation of any answers and additional evidence:	
The practice recognised that demand for appointments was high and was working collaboratively with the PCN to implement strategies to improve access.	
The practice had refreshed care navigation training for the reception team, so they were better able to direct patients to the most appropriate type of support or clinician. For example, the practice now had a range of appointments available at the main and the branch location with a clinical pharmacist, a first contact physiotherapy, a physician associate and an associate and trainee psychological practitioner trainee and associate	

psychological practitioner for low level mental health needs. Clinicians could also refer patients to a social prescriber if the patient needs were more of a social nature.

The practice implemented a PDSA Quality Improvement Plan to improve access for patients late in 2022. The action undertaken to improve access Included:

- Review of nurse appointment to identify the best appointment times and to reduce duplication.
- Routine GP appointment times increased to 15 minutes to allow better continuity and quality.
- Duty doctor appointments to remain at 10 minutes to ensure good on the day access.
- To open online booking to free up phone lines.
- Use of a workflow tool to monitor appointments.

Evaluation of the above actions identified:

- The increased in routine GP appointment reduced the overall number of these appointments but data showed that there was a reduction in repeat appointments by patients.
- Improvements were noted in the uptake of nurse appointments from 95% uptake in August 2022 to 98% uptake in March 2023.
- Health care assistant appointments had a reduction in repeat appointments and in the number of patients who did not attend their appointment.

At the time of this inspection a second cycle of PDSA Quality Improvement Plan was being implemented.

The objectives of this improvement cycle included:

- Promoting the online GP practice consultation tool to the patient population
- Educating the public about the ARRS role and including their roles within the workflow tool to monitor usage of the appointment slots.
- To offer all patients a routine appointment within a 2 week timescale.

The practice manager confirmed that 80% of appointments were now undertaken face to face (an increase of 5% since our previous inspection) with the remaining 20% were undertaken as telephone consultations.

Children under 5 years of age, older patients and vulnerable adults were offered a same day consultation with the duty doctor.

The nurse practitioner undertook home visits for older and vulnerable adults and worked closely with the integrated care team to ensure care packages of treatment and support met patients' needs.

25% of appointments were available to book online, and patients could re-book routine appointments up to 16 working days in advance with a named clinician.

The practice had recruited two salaried GPs and it was anticipated this would assist in increasing appointments.

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2023 to 30/04/2023)	49.0%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	65.5%	51.3%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	52.5%	48.1%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	76.6%	69.6%	72.0%	No statistical variation

Any additional evidence or comments

The practice scored on the whole, higher than GP practices when compared with GP practices within the local integrated care board and in England. The practice team recognised that more work was required to improve their patient survey results and access for their patients.

The practice was recognised in the local press as being the 2nd highest in the PCN for patients who were satisfied with the available appointments.

Source	Feedback
NHS.uk website (formerly NHS Choices)	No feedback had been left on the NHS website.
Patient feedback	One patient told us they had had the opportunity to ask questions of the practice manager about appointments and access and now understood better the issues affecting the availability of appointments.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	10
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Any additional evidence

The practice manager logged complaints within a spreadsheet which enabled leaders to have an overview of these and identify any themes and trends. We noted the practice's complaint procedure did not include a date or timeline for when the complainant could expect a final outcome letter to their complaint. We observed that patients did receive an acknowledgement to their complaint within a few days of receipt but the final outcome letter was on occasion a lengthy time after receipt of the complaint. We discussed this with the practice manager and referred them to the NHS complaint regulations which require an outcome date to be included within the complaints procedure. The practice manager confirmed they would update their complaints procedure immediately.

Well-led

Rating: Good

At our inspection in July 2022 we rated the practice requires improvement for providing well led services as we found some governance systems and monitoring processes were not sufficiently established which resulted in gaps in service quality. This inspection identified that systems of quality assurance and governance were now established and these had informed the practices wider improvement strategy.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: The GPs and the practice team had worked together to respond to all the areas identified at the previous inspection and this inspection enabled us to see the improvements made in all the areas previously identified. At our previous inspection, the practice leaders explained they felt they were in a post pandemic firefighting mode trying to address all the challenges reactively. Since then at this inspection, the practice leaders stated they were able to be more proactive and had developed and implemented different strategies to improve the quality of service for patients and for staff. There was recognition that further improvement work was needed. This included improving communication strategies for the reception staff team across both GP surgeries. Staff feedback forms from the reception team indicated they felt communication was an issue and the opportunities to have reception team meetings were limited due to the demands of staffing 2 locations. We discussed these concerns with the practice manager who confirmed they were aware and had introduced strategies to assist in communicating more effectively between the 2 surgeries. Including introducing a new role of senior administrator based at the Great Harwood GP surgery, to provide advice, support, and share information with the team there. They also demonstrated they were seeking solutions to allow the reception team to hold reception team meetings regularly, without impacting on service provision.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: The inspection in July 2022 identified opportunities to meet and discuss practice issues, including performance and well being were limited. Evidence from this inspection identified that regular clinical meetings, practice nurse meetings and partner leadership meeting were undertaken. These provided opportunities to review performance, including significant incidents, complaints, performance data and targets and to discuss and share opinions. Reception team meetings had been undertaken but these had been at infrequent intervals. One GP partner was the clinical leader for the PCN and collaborative working was established with the other GP practices to align and work to agreed priorities to improve patient services in their local community.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y

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

Source	Feedback
Staff interviews	Staff we spoke with were clear on their roles and responsibilities. Staff told us they worked well with their teams and that they enjoyed working at the practice. Reception staff felt comfortable sharing their concerns regarding the need for improved communication and increasing staffing to cover absences. Nursing staff told us they enjoyed their work, they said they were trained effectively and supported to develop and they had the autonomy to introduce strategies and protocols to improve patient care and treatment.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Leadership structures for the different areas of service delivery were displayed in the GP practice's two locations and staff we spoke with were clear about their and other roles and responsibilities.</p> <p>Since our previous inspection, the practice had implemented an action plan to address all the areas identified at the previous inspection and this was aligned with the practice's business development plans for the service. This inspection identified improvements in all the areas previously identified as requiring improvement.</p>	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Quality improvement plans were in place and actions implemented to improve service quality were effectively established. Systems to monitor performance were also in place.</p> <p>A range of environmental and clinical risk assessment were in place and we saw evidence of effective use of software programmes to ensure patients health, safety and wellbeing were prioritised.</p>	

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.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y

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.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y

The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group (PPG).	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Since the last inspection, the practice had ensured a range of staff meeting were undertaken and most of these were at regular intervals. Practical solutions were being identified to increase the number of reception team meetings and this included using the recently re-introduced protected learning time sessions. All staff had an appraisal since the last inspection and this enabled staff to comment on their own development and wellbeing.</p> <p>The practice manager had been able to recruit 6 patients to a PPG that had previously been unused and 1 PPG meeting had been undertaken. Whilst 2 people joined the most recent meeting, it was anticipated that more people would attend future meetings. The meeting minutes recorded 2 main themes of discussion raised by the attendees. These were 'access' and 'appointments.' The minutes detail the practice manager's explanation of the operation and the challenges around both these subjects.</p> <p>Collaborative partnership working was established with the PCN and other community health and social care teams.</p>	

Feedback from Patient Participation Group.

Feedback
<p>One patient who was also a member of the PPG told us about the recent meeting they attended. They told they now understood better how the appointment system worked and why they sometimes had to wait in a queue on the telephone. They said the practice manager listened to them and they 'felt valued' and 'felt part of something.'</p> <p>The patient also stated reception staff were always 'pleasant and polite' and felt the staff went 'above and beyond' on more than one occasion. They also commented positively about the quality of clinical care and treatment they received from GPs and the practice nurses.</p>

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was a commitment from all staff to deliver a safe quality service to their patients. Concerns identified previously had been actioned and were monitored to ensure improvements were sustained.</p>	

Examples of continuous learning and improvement
<p>Since our inspection in July 2022 the GP and practice team have refreshed care navigation training to assisting in using their allocation effectively of staff recruited by the PCN under ARRS.</p> <p>A range of clinical and non-clinical audits were established and used to review and improve service quality.</p> <p>A further PDSA cycle to improve patient access was in progress.</p> <p>The nursing teams identified strategies to improve patient understanding of health conditions such as creating information packs for newly diagnosed diabetic patients.</p>

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a “z-score” (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 practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice’s data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice’s data looks similar across two indicators, but they are in different variation bands. The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ‰ = per thousand.