

# Care Quality Commission

## Inspection Evidence Table

### Adlington Medical Centre (1-1503550346)

Inspection date: 3 & 7 December 2021

Date of data download: 02 December 2021

## Overall rating: Requires Improvement

The provider was rated good overall at the previous inspection in December 2016. At this inspection, the provider was rated requires improvement (RI) overall, with an RI rating in the effective and well-led key questions. The provider was rated inadequate in the safe key question and good in the caring and responsive key questions.

## Safe

## Rating: Inadequate

At the previous inspection in December 2016, the provider was rated good for providing safe services. At this inspection, the provider is rated inadequate for providing safe services because of a number of concerns we identified in relation to medicines management, recruitment systems, risk management and oversight. We identified breaches of Regulation 12 (safe care and treatment), Regulation 19 (staffing) and Regulation 17 (good governance).

### Safety systems and processes

**The provider had systems, practices and processes to keep people safe and safeguarded from abuse, but these were not always effective.**

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.	Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	

Safeguarding	Y/N/Partial
<p>The provider had DBS checks for the majority of staff but were unable to demonstrate that all staff had DBS checks. We found that one member of reception staff did not have a DBS check completed at recruitment. The provider assured us that reception staff would not be called upon to chaperone unless clinical staff were not available, and this member of staff had not yet chaperoned. We also found that a pharmacy member of staff had a DBS check from a previous role, but this had not been updated at recruitment. There were no risk assessments in place to demonstrate that the practice had considered the risk of these.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We found there were a number of concerns relating to recruitment processes. The provider was unable to demonstrate that they had conducted checks of conduct of staff from a previous employer for three members of staff, one of which was a doctor and one was a nurse. One other clinical staff member had a character reference and one receptionist had a partial reference from an employer, but the provider had not explored or documented why this staff member had been dismissed from previous employment.</p> <p>Following the inspection, the provider informed us that they had had a conversation over the telephone with the employer of the staff member who had been dismissed and had decided that there was no risk. They had not documented this conversation, or their consideration of this risk as is stated in their recruitment policy.</p> <p>The provider also did not explore or document why one other clinical staff member had left their previous role involving working with children. Four out seven files that we viewed did not have signed contracts. We also found that staff inductions were inconsistently managed. We saw that two staff members did not have an induction documented and one clinical staff member's induction was an emailed list and was not recorded using the provider's standardized template. They had not considered the risk that elements of a clinical induction could have been missed if the standard template was not used.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: February 2021	Partial
There was a fire procedure.	Y
Date of fire risk assessment: September 2021 Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We found that the provider had conducted health and safety risk assessments at the main location of Adlington and at the branch locations, but these were not always fully effective. For example, we found that legionella risk assessments that were completed as part of the health and safety process for Adlington and the branch sites had actions that had been raised but had not been completed.</p>	

## Infection prevention and control

**The provider did not have an effective system in place to determine if 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. Date of last infection prevention and control audit: January 2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Partial
Explanation of any answers and additional evidence: <p>The provider was able to demonstrate infection control audit activity when asked but this was not always fully effective. Cleaning at the main site and the branch sites were conducted by a contractor, site coordinators told us that they checked the standard of the cleaning with visual walk around, but there were no cleaning schedules in place and no formal oversight to ensure that all areas that required cleaning were completed by the cleaning contractor. The provider furnished us with infection control checklists (audits) for Adlington Medical Practice itself and for all of the branch sites of Adlington. We saw that actions on these checklists had no dates for completion or any indication of whether they had been completed. We also found that these checklists were ineffective; they stated that daily and weekly cleaning specifications were written down and were followed. The provider was unable to provide any evidence of this when asked. We observed that that provider's sites appeared clean and were tidy and well kempt.</p> <p>We saw that the provider had arrangements in place for the collection of waste and that a private contractor was employed to remove waste weekly. We found three examples of sharps boxes that had not been signed and dated, but all other aspects of waste were managed appropriately.</p>	

## 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: <p>The provider staff were able to articulate the red-flag symptoms of common conditions that they might come across in the course of their duties such as stroke, heart attacks and sepsis. Staff were aware of</p>	

the emergency processes and where to find emergency medicines and equipment. Staff were Basic Life Support (BLS) trained and up to date.

## Information to deliver safe care and treatment

**Staff did not always have 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 enable them to deliver safe care and treatment.	Partial
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Partial
There was a documented approach to the management of test results, and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N
<p>Explanation of any answers and additional evidence:</p> <p>The provider had identified a concern with the scanning of notes in 2020 and had put control measures in place to address this but had not yet run an audit to determine if this had been successful in solving the problem. We were told that there were some recurrent incidents of incorrect scanning following the establishment of the control measures, but these were reduced in frequency. The provider had not completed a theme analysis or were able to provide evidence to demonstrate this.</p> <p>The provider told us that they had experienced significant delays in referrals due to systemic issues outside of their control. Referrals were sent to a central hub where these were passed to the relevant services in secondary care or in the community. If these were not completed or there were delays, patients contacted the provider, whose only option was to re-refer into the same central hub. We asked the provider to show us data on the number of referrals that had failed or been delayed but they were unable to. Following the inspection, the provider added they did not have the ability to accurately track these and the data resulting from this would be outside of their control. In addition, we found that the provider had documented seven 'two-week wait' referrals (that were not controlled by the central hub) that had been missed or delayed due to staff error. The system in place for monitoring this was the significant event procedure, which did not outline sufficient actions or learning in relation to these events to ensure a failsafe. We asked the provider about this, who told us that staff would be checking these to ensure they happened, and this was the failsafe system.</p> <p>The provider was unable to demonstrate that there was appropriate clinical oversight of test results, we found five examples of blood tests in all the records we reviewed that had been ordered by clinical staff for patients requiring monitoring, which were not completed nor followed-up. Practice leaders told us that they had had issues with phlebotomy services run by the community health team that were outside of</p>	

their control. However, a system demonstrating oversight of test results for those blood tests that had been ordered was not in place or effective. The provider had offered phlebotomy services themselves to patients for a short period in 2021 but told us that they had been instructed to pause all routine blood monitoring by the Clinical Commissioning Group (CCG) during the worse period of the pandemic and vaccine roll-out. Documentation provided by the provider to support this demonstrated that they were informed that patients would have to book blood tests themselves and that doctors were no longer able to. This documentation did not support the provider's interpretation that all monitoring should pause. In addition, they continued to monitor patients in most areas of clinical practice but not all. For example, we saw that there were no issues with patients on most high-risk medicines and most long term-conditions.

The provider was unaware of the areas that we raised to them, demonstrating that these had not been paused deliberately. For example, when we raised the concerns about patients having more than recommended inhalers, the GP stated that this should not be happening and that he was unaware.

### Appropriate and safe use of medicines

**The provider had systems for the appropriate and safe use of medicines, including medicines optimisation but these were ineffective.**

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2020 to 30/09/2021) (NHS Business Service Authority - NHSBSA)	0.72	0.79	0.71	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). (01/10/2020 to 30/09/2021) (NHSBSA)	8.0%	9.9%	9.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2021 to 30/09/2021) (NHSBSA)	5.31	4.54	5.32	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	132.4‰	142.7‰	126.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2020 to 30/09/2021) (NHSBSA)	0.54	0.49	0.63	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	6.0‰	5.3‰	6.7‰	No statistical variation

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

Medicines management	Y/N/Partial
The provider 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.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The provider 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.	N
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	N
The provider 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.	Partial
The provider 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 Area Team Controlled Drugs Accountable Officer.	Y
If the provider 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 provider 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 provider 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.	N
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 PHE guidance to ensure they remained safe and effective.	N
<p>Explanation of any answers and additional evidence:</p> <p>The provider kept prescription stationary securely in most of the locations we visited, but its management was somewhat inconsistent in that logs were not always completed at Adlington Medical Centre. Following the inspection, the provider gave assurances that gaps in the prescription logs were in relation to days when clinical rooms were not being used. There was no evidence supplied to support this, however.</p>	



The provider told us that they had an open-door policy in relation to supervising non-clinical prescribers' staff. We spoke to these staff members and were told that they could approach clinical staff any time they were unsure and that the nursing team had a manager they could approach, as did the pharmacy team. We were told by the practice that formal supervisions did take place, including audits of treatment and prescribing decisions but the practice was unable to provide any evidence of these. Clinical oversight of nursing team and pharmacy team duties was absent.

We found that patients with asthma were not always reviewed effectively or that their repeat prescriptions were managed safely. We saw that 34 patients were prescribed more than the best practice recommendations of no more than 12 inhalers within a 12-month period. We looked at five records and found that in all five cases, the provider had allowed unlimited repeat prescriptions to be issued without appropriate reviews. In one case the patient was not coded for Asthma or Chronic Obstructive Pulmonary Disease (COPD), but it was documented in the patients record that they had severe COPD.

Two of these five patients had also had three sets of rescue medicines issued to them due to their limited control of their condition. We saw that despite this, the provider had reviewed these patients over the telephone. The provider investigated this and acknowledged that although reviewing these patients on the telephone was not good practice, they were attempting to balance the risk of Covid-19 infection of these vulnerable patients with their duty to ensure these patients were reviewed. The provider assured us following the inspection that they were able to use visual conference technology to review patients remotely and that none of these patients required emergency admission to hospital. They further stated that there was clear safety netting deployed to ensure that patients were closely monitored by the nursing team. Records we reviewed during the inspection did not contain details of a safety net system for these patients and there was no evidence that conferencing technology had been used. Following the inspection, the provider told us that they had reviewed all of the patients that we had identified as a concern and invited them for reviews. The pressures of the pandemic continue to impact on the provider.

We found a total of 157 patients that did not appear to have had appropriate monitoring completed in relation to taking high-risk medicines. For example, we noted 13 out of 19 patients who were taking Azathioprine (a medicine used to treat arthritis) did not have up to date monitoring. We checked five of these patients and found that all five had not had monitoring documented. In two of these cases, blood tests had been requested by the provider but had not been actioned and no follow-up activity to obtain an up to date blood test had occurred. One had been completed by the hospital, but this was not clear from the patient records and in one case, the prescribed amount of medication been reduced to encourage the patient to attend for monitoring. Following the inspection, the provider told us that all but one of these patients had now been reviewed.

Out of 52 patients taking ACE inhibitor or Angiotensin II receptor blockers (medicines use to widen blood vessels), we found that 22 appeared to not have monitoring; we checked five and found that all five did not have appropriate monitoring recorded. Records showed that some were perhaps completed by secondary care, but this had not been confirmed before prescriptions had been issued. Following the inspection, the provider told us that all but nine of these patients had now been reviewed.

Out of seven patients taking Amiodarone (a medicine to treat heart rhythm irregularities), three had not had appropriate monitoring completed. Records we reviewed confirmed this. Following the inspection, the provider told us that all but one of these patients had now been reviewed.

Medicines management	Y/N/Partial
<p>Of the 221 patients taking DOACs (Direct-acting Oral Anti-Coagulants – blood thinning medicines), 119 had not had appropriate monitoring completed. We reviewed five records in more detail and found that all five had not had monitoring recorded. In four out of the five cases we reviewed, bloods had been requested, but not completed nor had a follow-up occurred to ensure the patients bloods were monitored. Following the inspection, the provider told us that they had begun to review all patients with outstanding monitoring outlined in our remote search of these patients. The practice acknowledge that this is an ongoing process.</p> <p>We asked the provider about these concerns who told us that it was the nursing and pharmacy teams who was responsible for monitoring of patients and test results. They were unable to demonstrate that there was any clinical oversight of these teams to ensure that patients were monitored appropriately. They reviewed some of these patients during the inspection and booked these patients in for a review as soon as possible. We also found that staff were acting outside of their competencies, records we reviewed showed that pharmacy technicians were performing medicine reviews for patients, often without patients present. This was occurring without appropriate supervision as monitoring that was lacking was not picked up during these reviews. Following the inspection, the provider provided us with assurances that no staff were acting outside their competencies but provided no additional evidence of this.</p> <p>The provider told us, following the inspection, that they had a dedicated team of staff that dealt with quality and outcomes framework (QOF) data. They ran reports, sent out invites for patients and booked in patients accordingly. The purpose of this team was to ensure that the practices contractual obligations to the delivery of services in clinical areas such as diabetes and mental health were completed so that payment could be received. The practice further informed us that there was a whole team approach to the monitoring of QOF on an ad hoc basis. However, evidence we obtained through reviewing clinical records demonstrated that this was not always fully effective.</p> <p>The practice used a system of templates to document their consultations for patients with conditions that required ongoing management. This was designed to monitor and oversee patient recall, but this was not always effectively used.</p> <p>The provider did not have controlled drugs on the premises.</p> <p>The provider was unable to demonstrate that there was a consistent approach to the management of emergency medicines. We found that there were different systems at each branch site and at the main location for recording and storing these medicines. At Adlington Medical Practice (main location), we saw that seven of the recommended emergency medicines had not been stocked and no risk assessments were in place to consider the risk of this. We found that at the Medicare branch site, four of the stocked emergency medicines were dated as expiring at the end of November 2021, this had identified by staff but not removed. At this branch we found that these out of date medicines had replacements on site too. We also found that six of the recommended emergency medicines were not available and no risk assessment in place to mitigate the risk to this. At Crosten Medical Centre, another branch location, we found that one of the emergency medicines was dated November 2021; staff had identified this but there were no actions recorded and the medicines were still present. Four of those recommended medicines were not present, along with no risk assessments. We also found that there was no system to check these medicines in when they arrived at the practice, staff told us that sites shared medicines but there was no log of what medicines had gone where and there was also no log of medicine usage to ensure that none had gone missing. Following the inspection, the provider gave</p>	



Medicines management	Y/N/Partial
<p>assurances that a new monthly audit check and new stock monitoring process would be completed to ensure better compliance going forward.</p> <p>In all sites, we found that oxygen was stocked and that defibrillators were also present and all were in working order; we found that at Village Lostock Hall, the oxygen cylinder was kept inappropriately on the floor beside the door in a clinical room. Staff told us it was too heavy to be mounted on the wall. Staff relocated it to a more secure location once the inspection team had raised the safety concern.</p> <p>We saw that vaccine fridges were not always monitored appropriately, expiry dates were not always logged or monitored at all sites, temperatures were monitored daily but the system in place was ineffective. Practice leaders told us that nursing staff were responsible for monitoring fridge temperatures, but nursing staff we asked told us that they were unclear who was responsible and that anyone who was working that day would complete the task. Admin staff told us that they would usually check the temperatures but were unclear what the procedure was if temperatures were higher than the maximum 8°C allowed. We saw that the temperature had gone over this on one occasion, at the Medicare Unit and although staff recorded this, there was no reason or actions documented. The provider was unable to demonstrate that there was any oversight of this and told us that data loggers that were present were not used. The provider also told us that they planned on using automatic data loggers, but this had not yet been actioned. The provider told us that they would be reviewing this to ensure this did not happen going forward. Following the inspection, the provider gave us assurances that they had developed a robust logging process and were in the process of purchasing an automatic data logger.</p>	

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

**The provider did not have a fully effective system to learn and make improvements when things went wrong.**

Significant events	Y/N/Partial
The provider monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Partial
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:	49
Number of events that required action:	46
<p>Explanation of any answers and additional evidence:</p> <p>The provider demonstrated that a system to monitor and review risk was in place and had several types of risk assessments to show us, but could not demonstrate that these were effective, that actions required had been completed or that all areas of risk had been considered.</p> <p>They had an established system to raise and log significant events and staff we spoke with were able to show us how this worked, however, this was not fully effective in that we saw that the log had actions that did not facilitate learning or were missing and that some information contained within it was</p>	

incomplete. For example, we saw that records of actions had been started but not completed and others that did not have actions associated with them at all. We further found that incidents that had occurred and been logged in the accident book at Adlington had not been raised as significant events. The provider had identified themes for example, in relation to scanning incidents, but these were not formally documented. They also documented positive significant events to ensure learning from those as well. There were three of these documented in the last 12 months.

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

Event	Specific action taken
Two week wait referrals	The provider logged seven missed 'two-week wait' referrals since the middle of 2020 but had not produced a cohesive action plan to address this. Their documented action for the latest incident was a discussion to occur at the next time meeting in December 2021. For earlier incidents, actions recorded were to ensure tasks were sent to reception staff to send referrals, remind doctors to send referrals and the others had no actions recorded. For this issue, there was no theme analysis or overall actions taken to address it.
Scanning	The provider explained that they had identified errors with scanning as a recurrent issue and had retrained the staff involved. They had also ensured a second layer of staff were checking scanned documents on the records. They told us that the frequency of these occurrences had reduced but could not provide any specific evidence of this such as a theme analysis.
Positive comments	The provider had raised three positive significant events, which involved positive comments from patients.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider had a system in place to identify, disseminate and act on safety alerts, but this was not always effective. For example, we found that 12 patients had been affected by Medicines and Health Regulatory Authority (MHRA) alerts that had not been actioned. We found that one patient with advanced cardio-vascular problems was prescribed Febuxostat (used to treat chronic gout) and 11 patients over 65 were prescribed Citalopram (used to treat mood disorders) 40mg tablets and had not been advised of the dangers outlined in the MHRA alerts. Information provided by the provider suggested that of the 12 patients on Citalopram 40mg four of these patients had had a review and had the number of tablets they were prescribed reduced, six had been invited for a medication review but had not yet responded and 2 were overdue reviews. The provider was unable to provide evidence that discussions had taken place in relation to the medicine safety alert.</p>	

## Effective

## Rating: Requires Improvement

The provider was rated good for providing effective services at the previous inspection in December 2016. At this inspection, the provider is rated requires improvement for providing effective services because of concerns in relation to management of asthma patients and those who required regular monitoring. We also found concerns with systems in place to govern staffing.

*QOF requirements were modified by NHS England 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 not always effectively assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The provider 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.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Partial
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The provider had prioritised care for their most clinically vulnerable patients during the pandemic	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider was unable to demonstrate that all patients needs were fully assessed or that patients presenting with symptoms that could indicate serious illness were followed up. For example, Asthma patients who were prescribed more than the recommended number of inhalers and recorded as having limited control of their conditions, who had not had appropriate reviews conducted.</p> <p>We found a number of examples of patients on high-risk medicines, whose treatment had not been reviewed appropriately.</p> <p>The provider told us about significant delays in referrals due to wider systemic issues.</p>	

## Effective care for the practice population

### Findings

- The provider 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.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The provider 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.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The provider had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The provider demonstrated that they had a system to identify people who misused substances.
- The provider assessed and monitored the physical health of people with mental illness and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services. The provider told us that referrals to mental health services were taking anything up to 12 weeks in their local area as a result, they felt this was putting patients at risk. The provider had communicated this to the Clinical Commissioning Group (CCG) and local authority about this but told us they were unable to do anything more to address this.

## Management of people with long term conditions

### Findings

- We found that the majority of patients with long term conditions were managed well but that patients with asthma and COPD were not always managed in accordance with good practice guidance. We also found that there were nine patients that should have been diagnosed with diabetes, but the provider had missed this. We asked the provider about this and they explained that their new template system should have been flagging this up to staff who were responsible for reviews of these patients. The provider acknowledged that the template system would only work if the staff using it were coding patients correctly and explained that they would be conducting an investigation of this system. They explained that they would keep us informed of this. We asked who was responsible for this aspect of patient care and leaders explained that it was the nursing team who were responsible and had received specific training. The provider was unable to demonstrate any clinical oversight of this team. Patients who were correctly coded as having COPD were offered rescue packs. Following the inspection, the provider told us that these cases were not missed, but due to the difficult circumstances of the pandemic, these were a work in progress, they also told

us a dedicated team of staff had been set up following our visit to ensure proper call and recall happens going forward.

- Patients with asthma were offered an asthma management plan but several remained poorly controlled and follow-ups were not always completed.
- Patients with other 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.
- The provider told us that none of the patients they treated for an acute exacerbation of asthma had needed to be admitted to hospital. Records we viewed confirmed this, but the practice was unable to demonstrate that a system to ensure follow-up of these patients was effective.
- The provider could not demonstrate that they always shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions because coding was not always accurate.
- Adults with newly diagnosed cardio-vascular disease were offered statins. Patients with suspected hypertension were offered ambulatory blood pressure monitoring.

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)	24	24	100.0%	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)	21	22	95.5%	Met 95% WHO based target
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)	21	22	95.5%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	21	22	95.5%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	20	22	90.9%	Met 90% minimum

### Any additional evidence or comments

The provider demonstrated that they had not stopped seeing patients face to face during the pandemic and were able to achieve this through their multi-site model. They were able to continue to offer baby immunisation clinics and had achieved the national target in all five areas and the World Health Organisation (WHO) target in four of those areas.

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) (Public Health England)	72.7%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	67.1%	72.1%	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) (PHE)	57.2%	66.9%	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) (PHE)	61.1%	56.4%	54.2%	No statistical variation

### Any additional evidence or comments

The provider was aware of their lower than target cervical screening uptake score and explained that for a period they were without nursing services to facilitate this area. They had employed three nurses to address this lack of staff and had initiated cervical clinics. They were confident that this would improve their uptake scores going forward.

## Monitoring care and treatment

**The practice had a programme of quality improvement activity but there was scope to strengthen this further.**

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The provider had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The provider 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.

The provider had six audits completed by the medicine management team provided by the Clinical Commissioning Group (CCG), who had facilitated some positive patient outcomes. All but one of these audits were single cycle audits. The provider told us that they had not had time to do clinical audits themselves but had engaged in quality improvement activity. For example, putting control measures in place to address a recurrent scanning issue. The practice had not audited this to ensure that these measures had been successful.

## Effective staffing

**The provider was unable to demonstrate that staff always 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 provider 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.	Partial
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The provider could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
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>The provider was able to close one afternoon a month to provide Professional Educational Training (PET) sessions for their staff. Staff we spoke with found these valuable.</p> <p>We found that the provider was unable to demonstrate that all new staff had inductions completed. Clinical and non-clinical staff had missing inductions on their files and when asked, the provider was unable to furnish us with these.</p> <p>We saw that non-clinical staff had their appraisals when appropriate and that clinical staff kept records of their clinical appraisals. We asked to see evidence of supervision of clinical staff and non-clinical prescribers, but the provider was unable to provide this. The provider was also unable to show evidence of oversight of different teams within the organisation such as the nursing and pharmacy teams.</p>	

## 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.	Y
Patients received consistent, coordinated, person-centered care when they moved between services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider had also employed care coordinators to ensure that patients were signposted to the most appropriate professionals when calling the practice for an appointment.</p>	

## Helping patients to live healthier lives

### Staff were consistent in helping patients to live healthier lives.

	Y/N/Partial
The provider 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 provider supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider had specialist diabetic and respiratory nurses on staff to ensure that patients received the most appropriate professional where necessary.</p>	

## Consent to care and treatment

### The provider was unable to demonstrate that it 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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Partial
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	N
<p>Explanation of any answers and additional evidence:</p> <p>We found no concerns with capacity for most treatment decisions in the patient records we reviewed. We looked at records in relation to six DNACPRs across the two main locations patient lists however, we found that three that were not in line with guidance. All three patients were diagnosed with dementia, two had their DNACPR decision discussed with carers at their care home, but not with their next of kin (NOK), who had lasting power of attorney (LPOA). The provider had assumed that capacity was lacking</p>	

for all three patients; for one of these patients, a capacity decision had been logged in 2016, but had not been reassessed for the recent DNACPR decision, one had a no capacity decision logged in July 2021, with no reassessment and one had no decision recorded and no assessment recorded either. Following the inspection, the provider gave assurances that they had developed a detailed log to ensure compliance going forward.

## Caring

**Rating: Good**

The provider was rated good for providing caring services because we saw that staff treated patients with respect and involved patients in their care, attempting to make patients stakeholder in their own health and well-being. We saw that the provider had not checked to see if areas of lower than average patient satisfaction had improved, but the provider used friends and family testing to monitor this more generally.

### Kindness, respect and compassion

**We saw that staff treated patients with kindness, respect and compassion. Feedback from the majority of patients was positive about the way staff treated people.**

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgmental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

Patient feedback	
Source	Feedback
NHS Choices	We found that out of three reviews left on the NHS Choices website in the last 12 months, two were negative about how those patients felt treated by staff. The provider had not responded to these comments. We asked them about this, and they informed us that they were unable to obtain the password to provide comment. They had contacted the provider to address this.
Friends and Family	Unverified data provided by the practice showed that out of 850 respondents to a question of whether patients would recommend the practice to their family and friends; 85% said they would, 4% said they were unsure and 11% said they would not.

### National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	81.9%	89.6%	89.4%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the	80.9%	89.0%	88.4%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)				
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	96.4%	96.0%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	59.0%	82.7%	83.0%	Variation (negative)

Any additional evidence or comments
The provider was aware of their lower than average scores on the GP patient survey but were unable to demonstrate any actions to address these areas. They explained that a small cohort of patients were sampled as part of the survey (130 patients) and that they had issues with outside agencies that had caused negative patient feedback. They had not conducted a survey of their own to verify patient satisfaction or to aid quality improvement activity and felt that only 59% of patients responded positively to their overall experience of the GP practice was due to issues with access caused by the previous telephone system.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	N

Any additional evidence
The provider demonstrated that they were working closely with the local council to regenerate the area by investing in a new development where they could offer services from, this included a supported living area for older residents, cafes, and pharmacy and other amenities.

## Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: The provider website facilitated patients to find information about community and other services designed to support patients.	

## National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	89.2%	93.1%	92.9%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	The practice had 234 carers on their register for Adlington MC. This is over 2% of the practice population.
How the practice supported carers (including young carers).	The provider was able to demonstrate that carers were offered health checks and flu jabs. They also provided information to carers about local and community initiatives to support them.
How the practice supported recently bereaved patients.	The provider told us that they would offer bereaved patients a face to face appointment to ensure that they were offered the most appropriate support.

## Privacy and dignity

### The provider respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y



## Responsive

## Rating: Requires Improvement

At the previous inspection in December 2016, the provider was rated good for providing responsive services. At this inspection, the provider was rated requires improvement for providing responsive services, because although evidence we reviewed confirmed that they had made significant changes to their systems to improve access due to patient feedback, including self-funding a new telephony system, they were unable to demonstrate the effectiveness of this new system, or that they had attempted to establish if patient feedback had improved as a result. They had increased the number of offered appointments and provided a range of allied health professionals for patients to see.

### Responding to and meeting people's needs

#### The provider organised and delivered services to try and meet patients' needs.

	Y/N/Partial
The provider 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 provider 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 provider complied with the Accessible Information Standard.	Y

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 8pm
Tuesday	8am – 8pm
Wednesday	8am – 6.30pm
Thursday	8am – 7.30pm
Friday	8am – 7.30pm
Weekends	8.30 – 12.30 (for telephone access)
Appointments available:	
Monday	8am – 7.50pm
Tuesday	8am – 7.50pm
Wednesday	8am – 6.20pm
Thursday	8am – 7.20pm
Friday	8am – 7.20pm
Weekends	8.30 – 12.20 (for telephone access)

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

- The provider had set up and staffed a Covid vaccination centre at Jubilee House in Preston. The staffing at the centre had been created as a separate team from the practice team and were able to demonstrate that they had vaccinated 103,000 people in the area and anyone who walked in, in the last 12 months.
- Patients had a named GP who supported them in whatever setting they lived.
- The provider was responsive to the needs of older patients and offered home visits (conducted by paramedics) and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP Out of Hours (OOH) service would respond quickly, outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred. If deaths occurred during normal working hours, the GP would respond directly.
- The provider liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- The provider held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. They demonstrated that they had acted beyond good practice in relation to one homeless patient who had stopped requesting his medicines and seemed to disappear. Working in the multi-disciplinary manner, they located the patient and were able to secure housing and registration at one of their branch sites. Furthermore, the provider had developed a homeless patient policy and protocol to ensure consistency and guidance for staff.
- People in vulnerable circumstances were easily able to register with the provider, including those with no fixed abode such as homeless people and Travelers.
- Additional nurse appointments were available until 7.50pm on a Monday for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practices were open until 8pm on a Monday and Tuesdays and had extended hours on Thursdays and Fridays. Pre-bookable appointments were also available to all patients at three of the four branch sites within the area (although these covered a large area), as the provider was a Primary Care Network (PCN) and a Primary Care at Scale (PCAS) provider. Appointments were available Saturday and Sunday 8am until 12.30pm.
- The provider adjusted the delivery of its services to meet the needs of patients with a learning disability.

### Access to the service

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

*The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.*

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize 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	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
<p>Explanation of any answers and additional evidence:</p> <p>In June 2021, the provider was released from their previous telephone system, which had been provided through CCG contract due to repeated safety concerns that were raised by the practice due to patients not being able to contact them. The provider purchased a new system at a cost of £30000 per annum covering both locations' patient lists. This system was independent and allowed the provider access to a dashboard that could be used to track and record calls. It also allowed for queue management; patients were advised where they were in the queue and offered them the option for a call back. Practice staff demonstrated that this system and the call back worked well, although many patients reported to the provider that they did not yet trust the call back feature, for fear of losing their place in the queue.</p> <p>Practice staff showed us the dashboard and we saw that on the day of the inspection, the provider had received 890 calls, that 337 had been answered and 359 had been missed. Out of the 359 that had been missed, 194 had been abandoned and 165 had been other "missed". We asked the practice to explain these numbers as roughly half of the calls seemed to have been missed altogether.</p> <p>Staff we spoke with explained that most of the abandoned calls had occurred before 8am when the practice lines opened, as patients would call in before that time to get in the queue early, but this is not how the system worked. The 165 other "missed" calls were due to a glitch in the system; if patients were put on hold, the system would then cut them off when an attempt was made to reconnect them. The practice raised a significant event about this and were contacting the provider to ensure that this did not reoccur.</p> <p>In addition, it was discovered by the provider's communication's officer that patients, booking online, were booking themselves in with inappropriate clinical professionals, for example, the practice nurse, rather than the nursing practitioner. There were seven instances of this on the day of the inspection. The provider raised another significant event about this to attempt to address it.</p> <p>We also saw that the dashboard logged the "current longest waiting time" which was five minutes and 23 seconds, the "average queuing time in the last hour", which was six minutes and 58 seconds and how many patients were waiting in the queue at that time, which was five, when we reviewed the dashboard.</p> <p>The provider told us that when appointments were filled, all patients were placed on an "on call" list for the duty doctor(s) to review and triage where necessary. These patients would then be advised to see the GP face to face if necessary, as with all other patients. Records we viewed confirmed this. They were specific that any patient that needed to be seen would be seen, but that they may have to wait depending on the severity of their need.</p>	

The provider had employed care coordinators to ensure that patients were directed to the most appropriate professional for their needs. Not all reception staff were care coordinators, but staff could communicate with these staff where necessary or ask their line managers for advice.

Site coordinators (site specific managers) and the practice manager engaged in meetings to discuss access and the data from the telephony dashboard regularly and conducted monthly audits of appointment numbers which appeared to be increasing.

For example, in September 2021, the total number of appointments offered for the GPs and the Nursing practitioners was 1092; with other professionals added, this number increased to 1470.

In October 2021, the total number of appointments offered for the GPs and the Nursing practitioners was 1137; with other professionals added, this number increased to 1677.

These measures were still newly deployed and were still developing, however.

### National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	40.5%	N/A	67.6%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	52.4%	68.3%	70.6%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	48.2%	65.0%	67.0%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	70.6%	79.7%	81.7%	Tending towards variation (negative)

### Any additional evidence or comments

The provider was aware of their lower than average GP patient survey results but told us that this was when they were operating under the old telephony system. They were confident that their new system would address many of the concerns of patients that had rated them poorly during the last survey. They had not conducted any patient surveys of their own to understand a more current level of patient satisfaction as they were busy with the vaccine rollout and the winter pressures.

They also explained that at frequent periods they had a number of staff working from home due to their personal circumstances and the national guidance. For example, the latest guidance published on the day of the inspection meant that at least two doctors who were pregnant would have to work from home, reducing the practice capacity. The provider used locum agencies to ensure patients were seen but were aware that patients would be unhappy with the inconsistency that locum use can appear to create.

Source	Feedback
NHS Choices	Of the three comments left on the NHS choices website in the last 12 months, all three were negative in relation to access to appointments at Adlington MC. The provider had not responded to these comments. We asked them about this, and they informed us that they were unable to obtain the password to provide comment. They had contacted the website provider to address this.

## 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.	147
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
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
Explanation of any answers and additional evidence: Out of the 147 complaints logged by the practice, 38 were in relation to telephony (which the provider was addressing), eight were in relation to appointments and two were in relation to opening times.	

Example of learning from complaints.

Complaint	Specific action taken
Telephony	The provider had used complaints about telephony to further motivate them to change their system and fund it for themselves to ensure patients had better access.

## Well-led

## Rating: Requires Improvement

At the previous inspection in December 2016, the provider was rated good for providing well-led services. At this inspection, the provider is rated requires improvement because we found that governance arrangements that were in place were not always effective and oversight from leaders of the various teams was lacking, meaning that leaders were unable to accurately understand what was happening in teams or at different sites within the organisation.

### Leadership capacity and capability

**Although leaders were compassionate and fully committed to high-quality care delivery, they could not always demonstrate that they had the capacity and skills to deliver high-quality sustainable care.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
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: Practice leaders were not always able to demonstrate that they understood the challenges to quality; we saw examples of concerns the inspection team raised that the practice leaders were unaware of, including clinical concerns with, amongst others, monitoring and safety alerts, as well as vaccine fridge management (cold chain), environmental risk management and recruitment. In some cases, such as with scanning errors and with telephony, where practice leaders were aware, they had taken action to address them and were responsive to the inspection team's concerns in reviewing what was raised. However, this was piecemeal and had not been followed-up with checks to ensure actions taken had been successful. Leaders were unable to demonstrate effective communication between teams, that oversight of delegated work was in place or that there was consistency across sites.	

### Vision and strategy

**The provider had a clear vision and strategy to provide high quality sustainable care, but this was not always effective.**

	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.	Partial
Explanation of any answers and additional evidence: The provider had extended services to include multiple sites over a period of time, from 2009 to 2021. A business plan was provided to us as part of the evidence we reviewed and was a living document that	



changed as circumstances changed. It included a clear mission statement that we saw posted in other sites within the organisations and staff we spoke with were aware of it.

There were systems and mechanisms in place to monitor progress from a business perspective; the provider informed us of plans to continue to reform and hone their services. There were also systems in place from a basic function perspective, but this was not effective as it failed to always flag concerns to the provider for action.

## Culture

**The provider had a culture which attempted to facilitate 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 provider encouraged candour, openness and honesty.	Y
The provider had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider told us of five cases in the recent past of where they had needed outside support with serious staff issues. They used an outside contractor to advise them of Human Resources (HR) issues and we saw that they had taken decisive action in those instances where it was necessary.</p> <p>The provider had also run a staff survey in 2020 to check the levels of staff satisfaction. We saw that many staff answered these questions positively, but in many cases, more than a third of staff answered negatively. We asked the provider what they had done with this information and stated this was linked to the serious staff issues where they had needed specialist HR support. As a result of this survey the provider had established a well-being offer for their staff which included employee of the month voting. This was rewarded with a voucher to well-known retailers, discounted days off or other choices through an employee benefits and reward platform. Staff also had access to trained counsellors through the same scheme to support them in their role through a difficult period. Staff days out, meals and celebrations also featured heavily in the providers offer to staff to facilitate well-being.</p>	

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

Source	Feedback
Staff interviews	Staff we spoke with were proud of the work they were doing, happy working at the practices and felt that they were well supported to complete their roles in very

	difficult circumstances. There was no evidence of closed cultures or toxic working environments.
--	--

## Governance arrangements

**The overall governance arrangements had gaps that rendered them not as effective as leaders felt they were or should be.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw that the provider had systems in place for all areas of care delivery and that policies and procedures were in place. Staff we spoke with understood where to find information and what their individual roles were within their individual teams.</p> <p>However, we found inconsistencies in the way that these system and policies were implemented. For example, duties conducted by the admin staff were the designated responsibility of nursing staff, such as checking vaccine fridge temperatures. We were told that nursing and pharmacy teams were responsible for duties that had not been completed or not followed-up, but these teams were unaware of these, nor had they been checked by a clinician acting as a supervisor. For example, blood tests that had been ordered but had not occurred or been followed up with the patient.</p> <p>They were further unable to demonstrate that systems and processes that were in place were always working as intended or effectively. For example, with risk management or recruitment.</p>	

## Managing risks, issues and performance

**The provider had processes for managing risks, issues and performance but these were not always effective.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
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>The provider had quality improvement and assurance systems in place, and when the practice found areas were in need of improvement, they took action to address this, but systems to look back and review the effectiveness of the actions taken were lacking. Their own systems of assurance had not picked up these concerns. For example, patients being prescribed more than the recommended amount of asthma inhalers with no appropriate reviews, missed diagnosis of diabetes and missed MHRA alerts.</p>	

We found that systems for identifying, managing and mitigating risks were not effective. For example, we found that legionella risk assessments had actions that had not been completed, that emergency medicines were not always managed safely and that risks in relation to the recruiting of staff were not considered. Staff were acting outside of their competencies in relation to medicine reviews (assurances were received following the inspection, that this was not the case, but no evidence was provided to support this).

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

	Y/N/Partial
The provider had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The provider actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider had ensured that they had not stopped seeing patients face to face during the pandemic due to their multi-site model, one site was used to see vulnerable patients, one for patients with possible Covid-19 symptoms and a third site used for routine and urgent conditions. Patients were offered telephone appointments and were triaged and seen face to face if necessary. Patients were also offered appointments with a range of allied health professionals employed by the provider, including paramedics, pharmacists and nurses. Care coordinators were in place to manage this signposting. Paramedics also attended home visits and contacted the GP if necessary, for further intervention.</p> <p>The provider was aware of backlogs and were managing these over time with the resources at hand.</p> <p>There had been changes made to infection control procedures during the pandemic, but as restrictions had eased, so had the necessity for these to continue.</p> <p>The provider was unable to allow staff to work from home during the pandemic due to the limitations of the telephony system they had been locked into, we were told. The new system, which had been in place since June 2021 now facilitated this and we saw the practice making arrangements for staff to work from home in response to the initialisation of the government's updated guidance around the pandemic.</p>	

## Appropriate and accurate information

**The provider could not always act on appropriate and accurate information as their systems did not support them to do so.**

	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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The provider reviewed information on performance and used this information to improve, but systems did not always flag issues for the practice to review. The lack of oversight of clinical areas facilitated silo working between teams and gaps were present as a result. For example, clinical monitoring.</p> <p>We found that there was one example of where a statutory notification was not submitted as required. We made the provider aware of this, but this had not yet been completed.</p>	

**Governance and oversight of remote services**

	Y/N/Partial
The provider 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 provider 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 provider 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 provider advised patients on how to protect their online information.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider had developed a comprehensive and wide-ranging system to ensure compliance with information governance and information sharing protocols. They demonstrated that this had been running for a number of years and had dealt with extensive data requests from patients, legal firms and companies. We saw that these had been dealt with in line with legislation and guidance.</p>	

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

**The provider involved the public, staff and external partners in their ongoing efforts to provide high-quality and sustainable care.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The provider had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The provider worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: The practice had an active and comprehensive engagement and communication strategy with patients, they had employed a communications officer, whose responsibility it was to ensure social media platforms were managed and produced a newsletter on a weekly basis. The practice website also provided a large amount of information for patients. The provider also performed exit meetings with patients in order to determine if they could do anything better following a patient leaving their list.	

### 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.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: The provider had conducted exit interviews and audits with 87 patients that had left the practice lists to determine what the issues were and if anything could be learned. They found that issues that had contributed to this were the older telephony system, being unable to get an appointment, people moving out of the area and attitude of staff. The provider had taken action to address these concerns and were confident that this decline in patient numbers would be preventable going forward.	

### Examples of continuous learning and improvement

We saw that the provider had systems in place for significant events, quality assurance, quality improvement, complaints, risk and innovation, but not all of these were working effectively. They had a number of areas of innovation, including their vaccine centre and their drive to involve and support young carers. The provider acknowledged that there was a need to collate data on other such activities so that their innovations could be celebrated.

## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.
- 
- % = per thousand.