

## Inspection Evidence Table

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Inspection Date: 18 May 2023

Date of data download: 25/04/2023

## Overall rating: Not rated at this inspection

This was a responsive focused inspection looking at premises only.

### Safe

### Rating: Inspected and not rated

This was a responsive focused inspection based on information received by the Care Quality Commission (CQC) and looked at the premises to ensure they were in a fit state of repair. As part of the inspection and to ensure management systems were being operated safely and appropriately, we included personnel files, safety systems and records, health and safety, infection control and significant incidents.

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 UK Health and Security Agency (UKHSA) guidance if relevant to role.	No
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>We saw that the required pre-employment checks were undertaken for all incoming staff such as confirmation of identity and ability to undertake the required role. However new staff were not asked about their vaccination through pre-employment checks, in line with current guidance and existing staff had not been asked to clarify that their immunisations were up to date.</li><li>The practice did not have an effective employee immunisation system in place to ensure that all staff were protected against for infectious diseases such as, tetanus, diphtheria, polio and mumps, measles and rubella as well as hepatitis.</li></ul>	
Safety systems and records	Y/N/Partial

Health and safety risk assessments had been carried out and appropriate actions taken.	Partial
Date of last assessment: 12 April 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: 22 February 2023 and April 2023	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The health and safety assessment that had been undertaken had not identified all current risks. We saw glass topped tables in the staff kitchen, ligature points in pull chord blinds, and a ceiling hatch which did not have a lock and had possibly blown open or been left open during maintenance.</li> <li>A Legionella report dated 22 February 23 had been completed. All results were found to be satisfactory.</li> <li>A fire risk assessment was undertaken on 22 February 2023 when the fire service visited the premises and requested further assurances. Fire assurances were obtained in April 2023 and a satisfactory standard of fire safety was documented as evidence in the areas observed by the visiting professionals. Outstanding actions on fire management and risk had been addressed. The fire service had been in to upgrade the smoke alarms and the premises was passed as fire safe and compliant.</li> <li>Staff had been trained in fire safety, fire marshals were in place and could demonstrate what they would do in event of fire and all staff spoken to were aware of actions to take to keep patients safe. All this was in conjunction with the other practice and fire safety training had been completed. All appropriate action around fire safety had been taken. There was also a difference of opinion between the two practices that use the premises about a door that should remain locked. It is a fire safety door but also a security risk if left open/unlocked. This was something that was being monitored to ensure any security or fire risks were mitigated.</li> <li>There was one area of concern around the effectiveness of a fire door in the plant room, and this was under review between the practice/landlord and Cheshire Fire service.</li> </ul>	

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were mostly met.**

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Partial
Date of last infection prevention and control audit: 11/01/2023	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.	Y

Explanation of any answers and additional evidence:

- An infection prevention and control audit had been undertaken by the community IPC service and had identified areas that required attention. For example, in the storeroom a window required replastering to make it dry and IPC complaint. This had been done. Sinks in clinical rooms were not overflow free but this was on the current refurbishment plan.
- Holes to the wall from the electronic examination couch were noted and the practice planned some form of barrier to be applied to the wall to help reduce any infection risks.
- Sharps management had been reviewed during the IPC audit and the practice received 100 per cent compliance. However, sharps bins were not wall mounted and there was nothing documented to evidence that any risk of spillage had been assessed.
- Immunisations for staff were not carried out according to green book and this had not been identified.
- Clinical rooms were observed to be clean, clutter free and having necessary requirements such as elbow taps and suitable flooring with appropriate personal protective equipment (PPE).
- Fridges and the cold chain were well managed, and staff knew what to do in the event of any anomalies.

#### Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	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

#### 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

# Well-led

# Rating: Inspected and not rated

This was a responsive focused inspection based on information received into the Care Quality Commission and looking only at premises to ensure they were in a fit state of repair to keep people safe. As part of the inspection and to ensure management systems were being operated safely and appropriately, we included personnel files, safety systems and records, health and safety, infection control and significant incidents.

## 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: <ul style="list-style-type: none"><li>It was evident from discussions with the lead clinical GP and the practice manager that they understood what was required to maintain the premises to a satisfactory standard. They had addressed the immediate concerns and were in discussion with the landlord and the necessary building companies to make good any outstanding work required to keep people safe.</li></ul>	

### Governance arrangements

**The responsibilities, roles and systems of accountability to support good governance and management were not clear.**

	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.	Partial
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>The lead partner of the practice was also the landlord of the premises and the lines of responsibility between the landlord, the practice and the practice's practice manager were not clear enough to be effective. We discussed this during the inspection and the lead clinical GP agreed that clear lines of responsibility and a separation between the practice and the landlord company was something that needed to be introduced. The practice agreed to take this action forward.</li></ul>	

### Managing risks, issues and performance

**There was a processes for managing risks, issues and performance but it was not always clear who was responsible for this.**

	Y/N/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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>Although health and safety assessments and infection prevention and control assessments had been undertaken, not all risks had been identified. However, when risks were identified, such as the fire concerns and the concerns highlighted in the report and we saw that action was taken immediately to rectify those concerns.</li></ul>	

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: <div> <ul style="list-style-type: none"> <li>There were sufficient practice meetings and discussions to demonstrate that learning and improvement was discussed, and all staff were involved.</li> <li>It was evident that action was taken when things went wrong, and where concerns were highlighted.</li> </ul> </div>	

**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.