

# Care Quality Commission

## Inspection Evidence Table

### Culcheth Medical Centre (1-5190437536)

Inspection date: 20 May 2021

Date of data download: 27 April 2021

## Overall rating: Good

At the previous inspection 29 May 2019, we rated the practice Requires Improvement overall and for the key questions safe and well-led.

It is now rated Good overall. Improvements had been made to systems in a range of areas including management of medicines, significant events, safeguarding, complaints and notifications required to be reported to CQC.

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

## Safe

## Rating: Good

At the previous inspection in May 2019, the practice was rated as Requires Improvement for providing safe services because: the systems for ensuring staff were appropriately authorised to administer medicines to patients and for monitoring uncollected prescriptions were not robust. The systems for identifying and reviewing children and vulnerable adults subject to safeguarding concerns were not robust.

At this inspection, we saw that action had been taken to address the concerns to meet the requirement notices, most of the recommendations at the last inspection had been actioned and improvements had been made.

### Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y

<b>Safeguarding</b>	<b>Y/N/Partial</b>
Policies and procedures were monitored, reviewed and updated.	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.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	
<p>The practice had a local safeguarding policy available alongside a comprehensive range that had been produced by the CCG. This included accessible policies and flowcharts to support staff when they had any safeguarding concerns.</p> <p>The current register for children where safeguarding concerns had been identified was up to date and alerts were placed on these children's records. This was discussed and updated during regular meetings with staff internally and also with safeguarding contacts from the CCG. However, we saw that although they were included on the practice register, alerts were not on the records of the family members of all children. This was rectified during the inspection. We were informed that processes were being updated that included regular checks of such alerts as part of the reviews.</p> <p>The practice had set up six weekly meetings with the relevant members of external teams to discuss safeguarding concerns and update relevant information. There were regular discussions with the health visiting team when required who were also invited to the safeguarding meetings.</p>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 11/11/2020	Y
There was a record of equipment calibration. Date of last calibration: 24/09/2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: 08/04/2021	Y
Actions from fire risk assessment were identified and completed.	Y

<b>Health and safety</b>	<b>Y/N/Partial</b>
Premises/security risk assessment had been carried out. Date of last assessment: Various dates for individual assessments	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Various dates for individual assessments	Y
Explanation of any answers and additional evidence:  At the last inspection in 2019, the building was noted to be very warm particularly in the summer months. Air conditioning had been installed and staff told us this has significantly improved the regulation of temperature.	

### **Infection prevention and control**

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

	<b>Y/N/Partial</b>
There was an infection risk assessment and policy.	Y
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:23/07/2020	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

### **Risks to patients**

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

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

### Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Improvements had been made to the system to monitor two-week wait referrals to ensure patients received clinical care from specialist services.</p>	

## Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) (NHS Business Service Authority - NHSBSA)	0.81	0.83	0.76	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). (01/01/2020 to 31/12/2020) (NHSBSA)	9.7%	7.8%	9.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2020 to 31/12/2020) (NHSBSA)	5.36	5.50	5.33	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	145.3‰	152.4‰	127.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) (NHSBSA)	1.02	0.92	0.67	No statistical variation

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

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

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Prescribing of hypnotic medication had improved since the last inspection.</p> <p>Authorisation of patient group directives (PGDs) had improved since the last inspection, all of those reviewed met requirements. The system for ensuring prescriptions were collected had also improved to ensure vulnerable patients had appropriate follow up reviews and contact when required.</p> <p>We reviewed the records of patients prescribed different medicines which required additional monitoring. One medicine, which 338 patients were prescribed, required creatine clearance (a calculation to estimate kidney function). We reviewed records and found that 265 had not had this checked in the last 12 months, 156 patients had never had this checked. Of these 338 patients, 37 required blood monitoring. The practice was aware of this prior to the inspection and was taking action to complete these for patients. On the day of the site visit we saw that one patient still required creatine clearance and one patient required blood monitoring. The GP partners confirmed they would continue to undertake monitoring for the remaining patients and had a plan to do so.</p>	

Medicines management	Y/N/Partial
Fridges that stored vaccines had a warning sign on the plug to ensure they were not switched off. The practice used data loggers and monitored temperatures twice daily.	

### 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.	Partial
Number of events recorded in last 12 months:	11
Number of events that required action:	11
Explanation of any answers and additional evidence:	
<p>Staff were aware of the process for reporting significant events and told us they were updated with information from investigations, outcomes and actions. We saw significant events were discussed during weekly clinical meetings with minutes shared to inform staff of any action required.</p> <p>There had not been an annual review of significant events to ensure that any themes and trends over this time period had been considered.</p>	

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

Event	Specific action taken
External loss of power to the premises including all fridges storing vaccines.	Fridge temperatures were checked for the time period affected, the manufacturers of vaccines were contacted and information sought to ensure the stability and potency of the vaccines. Relevant bodies were notified and guidance followed. Data loggers were ordered as the investigation identified that these would have been helpful for such an incident.
Missed referral to secondary care service when practice protocol had not been followed correctly.	The referral was followed up and the staff member provided with information about the correct protocol to follow.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y

Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	
There was a system in place for receiving and responding to patient safety alerts such as those received through the Central Alerting System. Medicines and Healthcare Products Regulatory Alerts (MHRA). These were discussed at weekly clinical team meetings and all staff signed to confirm they had read and actioned them appropriately.	

## Effective

## Rating: Good

### Effective needs assessment, care and treatment

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

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

## Older people

## Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received an assessment of their physical, mental and social needs.</li> <li>The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received an assessment of their physical, mental and social needs.</li> <li>The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.</li> <li>The practice carried out structured annual medicines reviews for older patients.</li> <li>Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.</li> </ul>



- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Appropriate vaccinations were offered to patients in the relevant age group including flu and COVID-19 vaccines.
- Clinical staff attended home visits for patients who were unable to attend the practice. The practice had a daily on call GP who managed urgent appointments, telephone calls and home visits.
- The lead GP visited all patients residing in nursing homes on a weekly basis. This provided continuity of care and helped to prevent unnecessary hospital admissions.
- In the last 12 months the practice had carried out welfare checks on patients over 75 years of age.
- Members of the administrative team assisted patients unable to access the electronic consultation system by completing the required information. The team also assisted with online prescription orders over the telephone for older patients.

## People with long-term conditions

Population group rating: **Good**

### Findings

- Patients with long-term conditions were included on a register and offered a structured annual review to check their health and medicines needs were being met. These had mostly been carried out remotely during the 12 months prior to the inspection however patients with more complex needs were invited for a face to face review.
- Patients with multiple long term conditions were invited for extended annual review appointments.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Patients with asthma were offered an asthma management plan.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	80.1%	78.9%	76.6%	No statistical variation
PCA* rate (number of PCAs).	22.2% (192)	15.9%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an	90.5%	93.7%	89.4%	No statistical variation

assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>				
PCA rate (number of PCAs).	25.5% (54)	18.1%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	92.9%	84.6%	82.0%	Variation (positive)
PCA rate (number of PCAs).	7.2% (24)	5.6%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	61.3%	70.8%	66.9%	No statistical variation
PCA rate (number of PCAs).	11.3% (51)	19.1%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	68.9%	72.5%	72.4%	No statistical variation
PCA rate (number of PCAs).	3.2% (46)	7.1%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) <small>(QOF)</small>	96.0%	93.4%	91.8%	No statistical variation
PCA rate (number of PCAs).	2.3% (7)	3.7%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	84.7%	78.5%	75.9%	No statistical variation
PCA rate (number of PCAs).	9.1% (41)	11.6%	10.4%	N/A

**Findings**

- Data showed the practice has not met the minimum 90% World Health Organisation target for three of five childhood immunisation uptake indicators between April 2019 and March 2020. Data provided by the practice (unverified) showed all five childhood immunisations met the minimum 90%, with three exceeding the 95% target at the time of the inspection.
- The practice contacted the parents or guardians of children due to have childhood immunisations. Two nurses led a children’s vaccination clinic weekly. Letters were sent and telephone calls conducted to follow up and encourage attendance for those who had not attended for immunisations.
- The practice had arrangements for following up failed attendance of children’s appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice ensured that appointments were prioritised when there were concerns about a child.
- Appointments were available early mornings and late afternoons so school age children could attend.
- A sexual health clinic was provided which offered chlamydia screening.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	102	108	94.4%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	94	106	88.7%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	93	106	87.7%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	93	106	87.7%	Below 90% minimum

The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) <small>(NHS England)</small>	120	132	90.9%	Met 90% minimum
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Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

### Any additional evidence or comments

The practice was monitoring the performance against the targets for immunisations and provided updated information that showed all five childhood immunisations had met the World Health organisation target with three exceeding the 95% target.

At the time of the inspection all patients who had not attended for immunisation were on a register. The practice contacted patients on this register to encourage attendance by letter, text message and telephone calls. Information was provided to families about immunisations.

### Working age people (including those recently retired and students)

Population group rating: **Good**

### Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.
- Extended hours appointments were available so working age patients were able to access the practice outside of usual working hours.

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: 30/09/2020) <small>(Public Health England)</small>	76.2%	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) <small>(PHE)</small>	78.8%	73.3%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2019 to 31/03/2020) <small>(PHE)</small>	68.1%	N/A	63.8%	N/A

The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) <sup>(QoF)</sup>	97.6%	95.4%	92.7%	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) <sup>(PHE)</sup>	49.3%	45.3%	54.2%	No statistical variation

### Any additional evidence or comments

The practice was working towards improving uptake rates of cervical cancer screening. Appointments had been added to the online booking system and through the extended hours service. Invitations were followed up with telephone calls and the text messaging service.

### People whose circumstances make them vulnerable

Population group rating: Good

### Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice worked closely with community teams to help identify and support patients receiving palliative care. Multidisciplinary meetings were held every six weeks to help provide high quality care and meet the needs of these patients.
- Two members of staff were completing training to become cancer ambassadors to provide support for patients who had been diagnosed with cancer.
- The practice demonstrated that they had a system to identify people who misused substances.

### People experiencing poor mental health (including people with dementia)

Population group rating: Good

### Findings

- The practice maintained a register of patients who experienced poor mental health and used alerts on the patient records to clearly identify that additional support and priority appointments may be required. The register supported clinicians to offer patients an annual health check in addition to opportunistic reviews of their health needs.
- Same day and longer appointments were offered when required.

- There was a system for following up patients who failed to attend for administration of long-term medicines.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Some staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	63.0%	89.5%	85.4%	Tending towards variation (negative)
PCA rate (number of PCAs).	10.0% (6)	17.9%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	75.5%	81.3%	81.4%	No statistical variation
PCA rate (number of PCAs).	7.6% (9)	7.4%	8.0%	N/A

#### Any additional evidence or comments

The practice offered annual reviews as well as opportunistically reviewing patients experiencing poor mental health. The practice was monitoring attendance of these reviews, invited patients and continued to do so unless were informed that there was a reason for non-attendance.

#### Monitoring care and treatment

**The practice had comprehensively reviewed the effectiveness and appropriateness of the care provided.**

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	532.22	533.9
Overall QOF score (as a percentage of maximum)	95.2%	95.5%
Overall QOF PCA reporting (all domains)	6.3%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y

The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

- The practice had worked with the CCG on a project that reduced the number of urinary tract infections in registered patients aged over 65.
- There were regular audits of the cold chain to ensure the quality and safety of vaccines.
- An audit to review the monitoring of patients prescribed Amiodarone ( a medicine used to treat or prevent heart rhythm disorders) was conducted in January 2021. Findings showed not all patients had all of the appropriate blood monitoring or electrocardiogram (ECG) tests conducted as required. The outcome was to follow up with the identified patients and to re-audit on a regular basis.

Any additional evidence or comments
We saw that a range of audits had been conducted to monitor the quality of the care provided. The practice was in the process of formally planning the audit programme and outlining specific dates for these to take place.

### Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y



There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:  Monitoring of consultations, referrals and prescribing by clinicians had improved since the last inspection and was formally documented.	

### 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-centred care when they moved between services.	Y

### Helping patients to live healthier lives

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

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

### Consent to care and treatment

**The practice 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.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y

## Well-led

## Rating: Good

At the previous inspection in May 2019, the practice was rated as Requires Improvement for providing well-led services because: the systems for managing complaints and significant events did not ensure the learning and actions were fully documented so that they could be shared effectively with staff. The provider had not notified CQC of a patient death that may have been related to the regulated activity or how it was provided.

At this inspection we found that the requirement notice had been met, there had been improvements with communications, systems and processes had been strengthened and embedded and there was better oversight of all areas.

### 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:	
Improvements had been made to the management of complaints, there was a clinical lead in place and they were discussed in various meetings with outcomes and actions disseminated appropriately.	
Staff told us that there had been significant improvements overall with regards to the management of the practice since the last inspection. They said they felt supported and included by a visible and approachable leadership team.	

### Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y

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

## Culture

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

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

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

Source	Feedback
Staff interviews	Staff told us they felt supported and motivated working at the practice despite the challenges that they had faced during the COVID-19 pandemic. They felt included in changes and they told us that communication was good and they were listened to when they raised any concerns as well as seeing that action had been taken.

## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y

Explanation of any answers and additional evidence:

There had been improvements to the governance structures and systems since the last inspection. Clinical and non-clinical staff had lead responsibilities for different areas and ensured that appropriate action was taken when required. Information was discussed at meetings and feedback given to staff when required. Staff told us there was good communication across the team.

### Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Explanation of any answers and additional evidence:

The practice had made improvements in their assurance systems and these were embedded.

The practice had identified areas where quality improvement audits would be conducted however had not yet produced a formal plan outlining when these would take place and be reviewed.

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	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 practice 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

### Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection in 2019 we found that the learning points were not always clearly documented in complaints outcomes or in meeting minute to ensure learning was shared. At this inspection we saw that there had been improvements with the system to manage complaints, however the outcomes were not always clearly documented in the complaints log.</p> <p>The practice had not completed an annual review of significant events.</p> <p>The practice had appropriately notified CQC of significant events that met the criteria.</p>	

### Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y

The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<p>The practice reviewed a range of patient surveys to gain feedback and insight into potential improvements.</p> <p>The practice had an active Patient Participation Group (PPG).</p>	

#### Feedback from Patient Participation Group.

Feedback
<p>The Patient Participation group (PPG) met every eight weeks however this had not taken place in the 12 months prior to the inspection due to COVID-19. Regular communications had continued to be shared between the practice and the group over this time.</p> <p>We spoke with a representative of the PPG and they told us they were included and informed about any changes at the practice, consulted for views on the best options for patients and felt listened to. The PPG had been proactive in raising any issues and working with the practice towards improvements such as with the telephone system.</p> <p>Minutes from meetings with the PPG were shared with patients by newsletter and on the practice website. There was a meeting planned to be held by video call in the month following the inspection.</p>

## Continuous improvement and innovation

**There were 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:  Meetings provided opportunities for staff to receive information about important issues arising and changes were communicated by email as well as sharing the meeting minutes with all staff.	

## Examples of continuous learning and improvement

- The practice was working with the primary care network to develop services provided and improve outcomes for patients.
- During the COVID19 pandemic the practice conducted welfare checks to patients identified as being vulnerable or who may have difficulties accessing the online systems. The discussions with patients included how the practice could work to meet their clinical needs but also if they required any support with social needs such as food shopping and managing loneliness.
- The practice was involved with a project to identify and support the needs of military veterans.
- Plans to further improve the service included continued recruitment of staff and developing roles whilst reviewing the needs of the patient population to adjust services accordingly.

## 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.
- **\*PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#) ).
- %<sub>o</sub> = per thousand.