Care Quality Commission

Inspection Evidence Table

OHP - MGS Medical Practice (1-6448920075)

Inspection date: 21 July 2021

Date of data download: 21 July 2021

Overall rating: Good

At our previous inspection in December 2019 and January 2020 we rated the practice as Good overall but identified issues related the uptake of cervical cancer screening. We rated the corresponding population group Working age people (including those recently retired and students) as Requires Improvement and a requirement notice was issued. At this inspection we found that the practice had taken action to improve the uptake. The requirement notice has been removed and the population group Working age people (including those recently retired and students) rated as good. This change has been made because the practice had made significant progress over time to improve the uptake of cervical cancer screening. At this inspection however, we rated the population group, Families, children and young people as Requires Improvement because the uptake of childhood immunisations had decreased.

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

Safe Rating: Good

At the last inspection we rated the practice as good for providing safe services. However, recommendations were made because issues related to record keeping and health and safety practices were identified. At this inspection we found the practice had adequately addressed all the issues previously raised.

Safety systems and processes

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

Safety systems and records	Y/N/Partial
There was a fire procedure.	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: • At the last inspection in December 2019 and January 2020 the practice had not completed formal records of the outcome of fire drills to demonstrate regular fire drills were carried out and that staff knew what to do in the event of a fire. At this inspection the practice staff sent us copies of records detailing the outcome of fire drills carried out at all practice locations in January and April 2021. The outcome of the fire drill in January 2021 identified that although	

staff were aware of the procedures a quicker response was needed. The fire drill in April 2021 showed improvement and that appropriate actions were taken by staff.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	37
Number of events that required action:	37

Explanation of any answers and additional evidence:

- At the previous inspection we saw that information recorded in significant event reporting forms did not provide details on the investigative process and how this had been completed. There was no evidence of a focus on what had gone wrong and the actions required to prevent recurrence.
- At this inspection the practice told us about the action they had taken to make improvements, which included undertaking an audit of significant events reported between April 2020 and June 2021 to help identify any trends. Practice staff received training and attended regular meetings. Staff were encouraged to raise significant events as part of good practice and learning. Significant events were included as a regular agenda item at staff meetings. Staff were given lead roles and responsibility for implementing, monitoring and reporting on the effectiveness of action put in place.
- The practice shared a copy of the minutes of a meeting held to discuss significant events received between February and June 2021. The minutes of the meetings we reviewed were colour coded to show the discussion, agreed action and lead person, and learning to be shared with staff.

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

Event	Specific action taken
Insufficient information included in tasks to GPs resulting in a delay in acting on the task.	Staff were reminded of the procedures to be followed when assigning a task, which was also addressed through training. Staff were made aware of the importance of relaying prompt, detailed and accurate information.
Complaints from patients regarding access to the practice by telephone. Long queue times and calls dropped whilst waiting in queue.	Practice staff carried out an audit of the telephone system to identify problems. Meetings were held with the telephone company to discuss what improvements could be made. Consideration was given to replacing the system. Discussions were held with practice staff to gather their ideas on what improvements could be made.

Effective Rating: Good

Effective needs assessment, care and treatment

At the previous inspection in December 2019 and January 2020 we rated the practice as Good for providing Effective services. However the population group Working age people (including those recently retired and students) was rated as Requires Improvement and a requirement notice issued because issues related to the uptake of cervical cancer screening was identified.

At this inspection we found that the practice had taken action to improve the uptake of cervical cancer screening however the current data for the practice showed the uptake remained below the minimum target. Due to the action plan put in place to support improvements the requirement notice has been removed but the population group remains rated as requires improvement. Also at this inspection we rated the population group, Families, children and young people as Requires Improvement because the uptake of childhood immunisations had decreased and was below the national minimum targets.

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

Families, children and young people Population group rating: Requires Improvement

Findings
• The practice had not met the minimum 90% target or the WHO national target of 95% for any of the five childhood immunisation uptake indicators. The WHO target of 95% is the recommended standard for achieving herd immunity. The practice spoke about the action they had taken to improve the uptake and the impact the demographic challenges of the area and COVID-19 restrictions presented. • The practice had a previous performance history of not falling below the minimum 90% uptake and WHO target for most childhood immunisations over a period of four to five years, 2015 – 2019. A significant decline was noted for the year April 2019 and March 2020, which was before the announcement of COVID-19 restrictions. • The practice contacted the parents or guardians of children due to have childhood immunisations. • The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.

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)	91	103	88.3%	Below 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)	86	96	89.6%	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)	85	96	88.5%	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)	86	96	89.6%	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) (NHS England)	75	96	78.1%	Below 80% uptake

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

- At the last inspection we found that the practice was below the minimum 90% target for two of four childhood immunisation uptake indicators. Current data showed the practice was below the minimum target in all five indicators identified for this inspection. This meant that the practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity). Published data showed there had been a decrease in uptake between 2019 and 2020.

- We discussed the uptake of childhood immunisations with the lead GP and practice manager. The practice had carried out an audit to identify possible reasons for children not being brought for their immunisation. The practice had arrangements for following up failed attendance for children's appointments following an appointment in secondary care or for immunisation.

- The practice discussed any children not brought for appointments with the health visitor and other relevant professionals at regular meetings. The practice contacted the parents or guardian of children not brought for immunisation through text messages, letters and telephone.

Working age people (including those recently retired and students) — Population group rating: Good

Findings

- The practice uptake for cervical cancer screening showed a steady increase in uptake since the last inspection in December 2019 and January 2020, from 61% to 68% in March 2020.
- The practice staff had discussed how to improve the uptake of cervical cancer screening. Systems in place were reviewed and improvements made where appropriate. For example, changes were made to the call and recall system to ensure it was a proactive process and all patients followed up. Practice staff were reminded to check alerts on patient records and take the opportunity to offer patients an appointment for the procedure when they attended the practice.

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: 31/12/2020) (Public Health England)	68.0%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	57.3%	65.7%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	47.4%	54.9%	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) (QoF)	94.7%	84.6%	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) (PHE)	54.3%	47.9%	54.2%	No statistical variation

Any additional evidence or comments

- The practice was below the England average of the Public Health England target of 80% and just below the England comparison target of 70% for the uptake of cervical cancer screening. This data was collated at the time of the COVID-19 pandemic and periods of lock down which may have impacted on uptake.
- We reviewed the practice trend data for cervical screening and saw that although the 70% uptake had not been achieved there had been improved uptake over a period of five years. Data showed the uptake had improved by approximately 7% since the last inspection in December 2019 and January 2020. The practice achievement was slightly higher when compared with practices that experienced similar demographic issues.
- The practice had carried out an audit of cervical screening uptake at the practice. This highlighted some of the demographic reasons such as deprivation, language barriers, culture and religion that may have had an impact on the uptake by women. The practice offered women flexible appointments and provided information on the importance of cervical screening in different languages. Staff were made aware of the importance of understanding and being sensitive to the cultural issues related to the procedure.
- The practice screening rates for breast and bowel cancer was lower than the England averages. The practice had looked at how to support patients to recognise the signs and symptoms of possible cancer and to seek advice from their GP as soon as possible.
- Since our previous inspection there had been an increase in the uptake of bowel cancer screening and a significant increase in the percentage of patients with cancer, diagnosed within the preceding 15 months, who had a patient review recorded had occurred within 6 months of the

date of diagnosis. There was also a slight increase in the number of new cancer cases treated, which resulted from a two week wait referral.

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

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

- At the last inspection we found that clinical and internal reviews were completed at the practice but there were shortfalls in the information documented to demonstrate fully that an audit cycle process had been followed. The practice had introduced a new audit template for documenting the audit process. This guided the person undertaking the audit to follow the audit cycle process.

- The practice shared with us clinical / improvement audits that had been undertaken in the last year. One of the audits looked at the impact of COVID-19 on end of life care. The first cycle looked at the period March 2020 – September 2020 and the second cycle covered a seven month period, October 2020 to June 2021. The audit sought to review whether patients had the following in place; a preferred place of death, anticipatory medication, an advanced care plan, a DNACPR or not for DNACPR (do not attempt cardiopulmonary resuscitation) and a bereavement discussion. The outcome following the first audit cycle showed an achievement rate of 24% to 45% in the six areas. The second cycle identified significantly lower outcomes. The lower outcomes were reported to be due to the impact of COVID-19. One impact was the reduction of support from community nursing and palliative care services. Action planned included following up patients where possible. The practice planned to repeat the audit in April 2022 when support for primary care from community services may be restored.

Effective staffing

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

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

There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable	Yes
Explanation of any answers and additional evidence: • At the last inspection the practice employed three receptionists who had dual roles as health trainers. The practice advised that the trainers completed competencies to support them in this role. We found that the competency checks and the skills to be assessed were not specific and well defined to demonstrate performance expectations for the role. At this inspection the practice sent us a copy of the accredited competency tool they planned to use. We found that the skills assessed were more specific and relevant to the expectations for the role.	

Well-led Rating: Good

At the last inspection we rated the practice as good for providing well led services. However, recommendations were made because governance arrangements were not regularly reviewed. Effective arrangements for identifying, managing and mitigating risks were not consistently followed. There was a lack of documented information to demonstrate learning and improvements. The practice had adequately addressed all the issues previously raised.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: • At our previous inspection in December 2019 and January 2020 we found that there was a lack of information to demonstrate what issues related to audits, significant events and complaints had been discussed, specific action to be taken and details of learning shared with staff. At this inspection we found the practice had made improvements these included a review and update of paperwork and the documentation of records. For example, a new template which followed the audit cycle process was used for carrying out audits. The practice held monthly governance meetings with staff to ensure important information was shared and discussed.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: • At the last inspection we found that risk assessments had not been completed as part of the plan to demonstrate how risks to patients, staff and assets in the event of disruption to the service would be mitigated. We found that clinical and internal reviews were completed at the practice but there were shortfalls in the information documented in the audit records to	

demonstrate fully that an audit cycle process had been followed to support improvement and learning.
- At this inspection we found that improvements had been made. Health and safety assessments had been reviewed and updated. This included updates to reflect COVID-19 local and national guidance.
- There was a business continuity plan in place in the event of service disruption.
- The practice had carried out audits to support service improvements.

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes

Explanation of any answers and additional evidence:

- Patients that were potentially digitally excluded could still contact the practice via telephone and were assessed by a clinical member of staff. A face to face appointment was provided if needed.
- Home visits were available to the practice's most vulnerable patients.
- Through arrangements with the practice primary care network, patients were able to access additional video/teleconferencing consultations in the evenings and at weekends.
- Practice staff advised us that they actively monitored two week waits to ensure there were no delays. The practice also continued to manage symptoms for any patients whose treatment to secondary care was delayed.
- Infection prevention and control measures had been put in place to maintain staff and patient safety during the pandemic.
- There were arrangements in place for staff to work remotely to support the continuity of services, if needed.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes

Explanation of any answers and additional evidence:

- At the last inspection we found there was a lack of information to demonstrate learning and improvement.
- At this inspection systems had been introduced to enable staff to discuss incidents and complaints that had occurred. The practice learnt from incident's and complaints.
- At the last inspection we found that there were shortfalls to demonstrate learning and improvement from audits, significant events and complaints. At this inspection we found that the practice had improved and staff were involved in making changes and learning was shared with staff.The documentation of audit records had improved to demonstrate outcomes and support improvements in care and treatment.

Examples of continuous learning and improvement

- The practice worked with other practices within their primary care network group based in Wolverhampton, which provided peer support and opportunities for learning and improvement.
- The GPs, practice nurses and healthcare assistant attended regular online peer group meetings.
- The practice had agreed for one of their branch sites to be used as a COVID 19 vaccination hub. Staff had supported the COVID-19 hubs to deliver the vaccination programme. Sessions were also set up at a local mosque to provide reassurance and encourage uptake of the COVID-19 vaccine.
- The practice website had been updated to provide appropriate and up to date information and education for patients. For example, information on the importance of cervical screening was available in different languages on the website and could be easily accessed and downloaded by patients.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the 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.
- **PHE**: Public Health England.
- **QOF**: Quality and Outcomes Framework.
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ***PCA**: Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see GMS QOF Framework). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
-
- ‰ = per thousand.