

Inspection Evidence Table

Woodside Surgery

(1-541134350)

Inspection Date: 20 and 21 June 2023

Date of data download: 8 June 2023

Overall rating: Good

At our inspection on 30 and 31 March 2022 we rated the provider as requires improvement overall as safe systems and processes were not sufficiently well established, clinical effectiveness was not demonstrated, and governance processes were not fully established. At this inspection the provider demonstrated that they had made improvements in the areas of concern found at our previous inspection. We have now rated the provider as good overall.

Safe

Rating: Good

At our inspection on 30 and 31 March 2022 we rated the provider as inadequate for providing safe care as systems in relation to managing Medicines and Healthcare Regulatory Agency (MHRA) alerts, processes for management of medicines that require monitoring, and infection prevention and control measures were not effectively implemented.

A focused enforcement follow-up inspection was undertaken on 11 and 12 July 2022 where we found the provider had made improvements in the areas of concern found at our previous inspection.

At this inspection the provider demonstrated continued improvements. The provider is now rated good for providing a safe service.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes

There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
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.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At our last rated inspection in March 2022, we found some gaps in relation to evidence of uptake of safeguarding training. At this inspection we found that clinical staff were trained to safeguarding children and adults level 3 and non-clinical staff were trained to level 2 in line with national guidance. We saw staff had completed preventing radicalisation and domestic violence awareness training. All clinical and non-clinical staff we spoke with knew who the safeguarding lead at the practice was, how to access safeguarding policies and procedures and local safeguarding contact details. There were systems in place to follow-up on children with frequent attendance at accident and emergency and when children had not been taken to secondary care and childhood immunisation appointments. We saw that the safeguarding lead attended external Calderdale safeguarding meetings. Staff we spoke with were able to describe their role and responsibility when chaperoning. We saw that notices were displayed in consultation rooms to advise patients that a chaperone service was available, if required. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We reviewed 4 clinical and 1 non-clinical staff recruitment file, which included a locum GP. We found there was a system in place to check all relevant employment documentation in accordance with regulations. For example, photographic identification, references, Disclosure and Barring Service (DBS) and professional registration checks. The practice told us they captured the immunisation status of staff at the point of recruitment. From the selection of employment records reviewed we found that there were gaps in the full immunisation status for some staff. All clinical staff files we reviewed showed those staff were up-to-date with hepatitis B. The practice had undertaken a risk assessment for staff where immunisation evidence could not be provided, and some staff were due to have immunisation updates. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes
Date of last assessment:	15.05.2023 (3 Sites)

There was a fire procedure.	Yes
Date of fire risk assessment:	25.05.2023 (3 Sites)
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The service operated from 3 premises: a main surgery and 2 branch surgeries. We saw that the practice had systems and processes in place to ensure premises and equipment maintenance were undertaken at all 3 sites, for example the fire alarm system and fire extinguishers. • Portable Appliance Testing (PAT) and calibration of medical equipment had been undertaken for all 3 sites. • We saw evidence of a valid Gas Safety Certificate and an Electrical Fixed Installation Condition Report (EICR) for each site. There was some outstanding remedial action from the EICR for 2 sites which the practice was in the process of arranging out of surgery hours. • At our last rated inspection in March 2022, we found gaps in relation to evidence of annual fire awareness training for some staff. At this inspection we found all staff had undertaken fire awareness training. The practice had nominated fire marshals for all 3 sites, who had been trained for their role. • We saw staff had undertaken health and safety, control of substance hazardous to health (COSHH), moving and handling and display screen equipment (DSE) training. • We saw the practice was undertaking weekly flushing of the water systems at all 3 sites as part of their prevention and control measures to reduce the risk of Legionella and other bacterial growth. We saw the practice had booked legionella risk assessments for all 3 sites in August 2023 with an external contractor. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit:	May 2023 (3 Sites)
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • On the day of the inspection, we observed the premises to be clean, tidy and free from clutter. • At the time of our inspection the practice was undertaking quarterly infection prevention and control (IPC) audits at all 3 sites. • There was a nominated IPC lead. All staff we spoke with knew who the lead was. • At our last rated inspection in March 2022, not all staff had completed IPC training. At this inspection we saw that all staff had completed IPC training to a level relevant to their role. 	

- Bodily fluid spillage kits were available and all staff we spoke with knew where they were located and how to use them.

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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
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.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • At our last rated inspection in March 2022, we found gaps in relation to evidence of completion of basic life support training for some staff. At this inspection we saw that face-to-face training had been undertaken following our last inspection in April and June 2022. We saw that this year staff were completing online training. The practice planned to alternate between face-to-face and e-learning. We saw that all staff had undertaken anaphylaxis training. • The practice was equipped to respond to medical emergencies at all 3 locations. Staff were aware of the location of emergency medical equipment and medicines, for example oxygen and the automated external defibrillator (AED). • Sepsis awareness training for non-clinical staff formed part of the core online training schedule identified by the practice. Non-clinical staff were aware of 'red flag' presenting complaints, for example patients with shortness of breath, and what action to take if they encountered a deteriorating or acutely unwell patient. • The practice utilised the panic alarm system integrated into their clinical system. Staff we spoke with were aware of how to raise the alarm in the event of an emergency. 	

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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes

There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results, and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • From a selection of patient records reviewed. we saw that patient consultations contained appropriate information and demonstrated that care and treatment was being delivered in a safe way. • New patients registering with the practice were required to complete a registration form, where they were required to document any key information, such as allergies, medical history and prescribed medications. • The practice had a summarising protocol in place. Clinical records of new patients were mostly received by electronic transfer. Those that were received in paper form were summarised in the practice clinical record system. We saw from the clinical system that 78% of patient medical records had been summarised. At the time of our inspection, we saw several staff were undertaking summarising training to ensure there were adequate staff trained in this role. • We observed that urgent two-week referrals were dealt with appropriately and a system was in place to ensure they were sent in a timely manner and followed up. • We saw that the practice had failsafe systems in place for safety-netting cervical screening undertaken at the service, to ensure that a result was received for each cervical screening sample undertaken by their sample takers. • There were systems and processes in place to manage incoming clinical correspondence, tasks and referrals generated by the practice. • At our last rated inspection in March 2022, we found there was no formal process in place to oversee and monitor test results during the absence of staff. Following that inspection, the practice provided evidence of a formal protocol for management and oversight of test results, including a 'buddy' system to cover for staff absence. At this inspection we saw evidence that the deputising system was in place to ensure test results and patient correspondence were managed during staff absences. 	

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	1.29	1.07	0.91	Tending towards variation (negative)

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). (01/04/2022 to 31/03/2023) (NHSBSA)	3.7%	5.5%	7.8%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2022 to 31/03/2023) (NHSBSA)	4.79	4.82	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	258.2‰	162.1‰	129.8‰	Tending towards variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.92	0.50	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	11.1‰	7.7‰	6.8‰	Tending towards variation (negative)
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice was aware of their prescribing outcomes, and we saw medicine management and audits formed part of the provider's overarching governance structure. The practice engaged in the Lowering Anti-Microbial Prescribing (LAMP) project which enabled them to monitor their prescribing. The practice had an employed prescribing pharmacist and the support of the primary care network (PCN) pharmacists. The practice engaged in prescribing initiatives to ensure safe and effective prescribing. The practice had made some improvements to their prescribing outcomes since our last inspection. For example, at our last rated inspection in March 2022 we found: <ul style="list-style-type: none"> ➤ 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 was 8.4% compared to 3.7% at this inspection. ➤ The average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) was 1.02 compared to 0.92 at this inspection. 				

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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes

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.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Yes
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.	Yes
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
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.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> At our last rated inspection in March 2022, there were no processes in place to record and track blank prescriptions in the practice. At this inspection we saw that prescription stationery was securely stored and there was a system in place to record prescription serial numbers distributed to printers. Following inspection feedback, the practice told us they had commenced a system to remove prescription stationery from printers and securely store when the practice was closed. At our March 2022 inspection, there was no formal process in place to oversee and audit non-medical prescribers. At this inspection, the practice provided evidence of a process for quarterly review of non-medical prescribers' consultations and prescribing, which included primary care network (PCN) staff assigned to the practice. At our March 2022 inspection, we saw that vaccine fridges at the branch sites were not being checked daily. At this inspection we saw that actual, minimum and maximum temperature checks were undertaken daily for vaccine fridges at all 3 sites. The vaccine fridges had a secondary thermometer in line with guidance. Some administrative staff were responsible for checking and recording fridge temperatures. We saw they had received cold chain management training. Those who we spoke with knew what to do if the temperatures were outside the normal ranges. 	

- As part of our inspection, we conducted a series of searches to assess the practice's procedures around medicines management and prescribing. A review of the searches was undertaken by the CQC GP specialist advisor without visiting the practice. The searches were visible to the practice. We found:
 - There were 26 patients prescribed methotrexate, 9 patients prescribed azathioprine and 3 patients prescribed leflunomide. We found all patients prescribed these disease-modifying antirheumatic drugs (DMARDs), medicines used to treat rheumatoid arthritis and some other conditions, had been monitored appropriately. We reviewed 5 patients prescribed methotrexate and found systems and processes in place to ensure appropriate blood monitoring had been undertaken. However, we found for 2 patients prescribed methotrexate there was no day of the week on which the patient should take methotrexate recorded on the prescription. This has been a recommendation of a September 2020 MHRA alert. Immediately after the inspection the practice provided evidence that they had reviewed all patients prescribed methotrexate to ensure a day of the week was recorded on their prescription.
 - At our March 2022 inspection, we found processes for reviewing patients taking medicines requiring monitoring were not sufficiently thorough. At this inspection, we ran a search of patients prescribed 7 types of medicines that required monitoring. We found improvements had been made to systems and processes to ensure these patients had been monitored in line with guidance. For example, there were 32 patients prescribed warfarin (a drug used to thin the blood to reduce the risk of blood clots and stroke) and 6 patients prescribed lithium (a mood stabilising medicine used to treat certain mental illnesses) and we found none had outstanding monitoring. We saw that there were 832 patients prescribed an angiotensin-converting enzyme (ACE) inhibitor or an angiotensin II receptor blocker (ARB), which are used to treat raised blood pressure. We found 20 patients were noted to be overdue monitoring. We reviewed 5 patients and saw that 4 patients had received multiple reminders but had failed to attend for follow-up. After the inspection the practice told us they had discussed these patients and would continue to attempt to engage them in follow-up. In addition, they told us they had reviewed their prescribing policy for patients who do not comply with blood and other diagnostic testing to consider, where appropriate, issuing shorter prescriptions. We highlighted 1 patient with a view to immediate review to ascertain the welfare status of the patient as they had not recently requested any of their medicines. The practice followed-up with the patient's family and found they were no longer residing in the country.
- The practice was responsive to feedback from the remote clinical notes review and acted immediately upon our findings, including contacting those patients we had highlighted for follow-up.
- The searches showed that overall, the practice had made improvements to their systems and processes to manage patients prescribed DMARDs and medicines requiring monitoring. We saw that since the March 2022 inspection the practice had been undertaking regular audits to ensure these patients were being appropriately managed.

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:	4
Number of events that required action:	4
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • All staff we spoke with, and those who completed questionnaires, were aware of the process to record an incident. • We saw that staff had undertaken incident and accident reporting training. • Staff told us they were encouraged to report incidents and felt confident to do this. They felt they were able to raise and discuss concerns in an open environment. They told us they felt the practice clinical and management team were open and transparent. • At the inspection we reviewed a selection of incidents and saw appropriate action had been taken and learning shared through meetings. In particular, we saw evidence in the investigation of a vaccination error that the practice had applied the duty of candour. We saw that the patient had been contacted and an apology given. 	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • As part of our inspection, we conducted a series of searches to assess the practice's procedures around Medicines and Healthcare products Regulatory Agency (MHRA) alerts. Our search included 8 single drug safety alerts and 5 combination drug safety alerts. A review of the searches was undertaken by the CQC GP specialist advisor without visiting the practice. The searches were visible to the practice. We found: <ul style="list-style-type: none"> ➤ The practice had implemented systems and processes to receive, disseminate and act upon MHRA alerts. We saw that a log was maintained of all safety alerts received and action taken. ➤ At our last rated inspection in March 2022, some patients had not been appropriately assessed and the necessary adjustments to their prescribed medicines made. For example, we found 5 patients were prescribed the combination simvastatin 40mg (used for lowering cholesterol) and amlodipine (used to treat high blood pressure), which had been the subject of a MHRA alert issued in December 2014. At this inspection all patients on this combination were prescribed the appropriate dosage in line with guidance. ➤ There were 46 female patients of childbearing age prescribed a teratogenic drug. Patients prescribed a teratogenic drug, who are of child-bearing age, should be made aware of the risks with this medicine in pregnancy and have effective contraception. We reviewed 5 patients and found that although advice had been given this had not always been given in a timely manner, for example, at the commencement of the medicine. We saw that the practice had been alerted to this in an audit following our previous inspection and reviewed all patients on a teratogenic drug to ensure appropriate advice had been given. 	

- The searches showed that overall, the practice had made improvements to their systems and processes to manage MHRA alerts and patients on medicines subject to patient safety alerts.

Effective

Rating: Good

At our inspection on 30 and 31 March 2022 we rated the provider as requires improvement for providing effective care because quality improvement activity was limited in scope and processes for maintaining oversight of staff training updates were not sufficiently well established.

At this inspection we found the provider had made improvements in the areas of concern found at our previous inspection. The provider is now rated good for providing an effective service.

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Yes
The practice prioritised care for their most clinically vulnerable patients.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • We saw evidence from the clinical notes review that staff were following The National Institute for Health and Care Excellence (NICE) guidelines. 	

- Staff told us they were kept up to date with current evidence-based guidance through clinical meetings and in practice protected time.

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check. At the time of our inspection, we saw that there were 91 patients on the practice's learning disability register. We looked at unvalidated data provided by the commissioners on their quality, performance and contracting dashboard and found that the practice uptake for learning disability health checks for the 12-month period up to March 2022 was 92%.
- We saw that staff had undertaken learning disability awareness training.
- 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 had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services. We saw patients had access to a mental health practitioner at the practice.
- We saw that staff had undertaken dementia awareness training.

Management of people with long term conditions

Findings

- As part of the inspection, we conducted a series of remote clinical searches to assess the practice's procedures for the management of patients with long-term conditions. We found that the management of patients with long-term conditions, which included diabetes, chronic kidney disease, hypothyroidism and asthma was generally good. In particular, we found:
 - There were 37 patients (out of 556 patients on the diabetic register) with diabetic retinopathy, whose latest HbA1c was more than 74mmol/l. We reviewed 4 patients and found the management and referrals for patients with diabetes was good.
 - There were 22 patients with chronic kidney disease (CKD) stage 4 or 5, of which 2 had not had their urea and electrolytes monitored in the last 9 months. We saw both patients were being managed in secondary care. However, 1 patient had not attended their recent appointment. After the inspection the practice contacted the patient regarding their non-attendance and told us they would continue to monitor them.
 - There were 338 patients with hypothyroidism of which 10 patients had not had their thyroid

stimulating hormone (TSH) monitored in the last 18 months. We reviewed 3 patients and found 1 patient had recently been monitored and results were available through the web-based pathology platform. We saw 2 patients had received several reminders and had failed to attend. The practice told us they would follow-up on the patients identified through the clinical search.

- There were 72 patients (out of 952 patients on the asthma register) who had been prescribed 2 or more courses of rescue steroids in the past 12 months. Of the 5 patients we reviewed we noted that 3 patients had not been issued with a steroid card in line with guidance and 2 patients were overdue an asthma review. The practice told us they would review these patients.
- At our inspection in March 2022, we found there were 27 patients with a potential missed diagnosis of diabetes, of which the 5 we reviewed had not been appropriately coded as diabetic or pre-diabetic following abnormal test results. At this inspection we found there were 6 patients with a potential missed diagnosis of diabetes. We reviewed 5 patients and found some delay with the coding of 2 patients with diabetes, although their current HbA1c had reverted back to a pre-diabetes range, which was coded. We highlighted 1 patient to the practice for immediate review in relation to an abnormal test result. Immediately after the inspection the practice confirmed that an appointment had been booked for the patient. The practice told us they would review all patients in this category.

In addition to our clinical searches, we found:

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- 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.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardiovascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	81	91	89.0%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received	98	104	94.2%	Met 90% minimum

Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)				
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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	98	104	94.2%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	98	104	94.2%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	93	112	83.0%	Below 90% minimum

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

Any additional evidence or comments

- The practice held regular childhood immunisation clinics and had a recall system in place. The practice also liaised with local health visiting teams, where appropriate, to follow up with families where parents or carers had failed to bring babies and children for vaccination.
- The practice was aware that some of their childhood immunisation outcomes were below the target uptake. However, we saw that there had been some improvements in uptake since our last inspection in March 2022. For example, we found:
 - The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (PCV booster) was 94.2% compared to 83.8% at our previous inspection.
 - The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) was 94.2% compared to 83.8% at our previous inspection.
 - The percentage of children aged 2 who have received immunisation for measles, mumps and rubella was 94.2% compared to 84.6% at our previous inspection.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	8.9%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	67.5%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for	65.1%	N/A	80.0%	Below 70% uptake

persons aged 50 to 64). (12/31/2022 to 12/31/2022) (UKHSA)				
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	48.8%	59.4%	54.9%	No statistical variation

Any additional evidence or comments

- The practice was aware that their cervical screening uptake was below the 80% target. They told us they actively and opportunistically encouraged eligible patients to have cervical screening. We saw there was a recall system in place and systems in place to follow-up non-attenders.
- The data available to CQC for breast screening for the period April 2021 to March 2022 showed that uptake was only 8.9%. The practice told us that they had been aware of capacity constraints during this timeframe at the breast screening service. We looked at more recent unvalidated data provided by the commissioners on their quality, performance and contracting dashboard and found that the practice uptake for breast cancer screening for the period up to October 2022 was 58%.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	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
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ul style="list-style-type: none"> • At our previous rated inspection in March 2022, we found the practice had not initiated any recent internal quality improvement. At this inspection we saw the practice had commenced a schedule of non-clinical and clinical audit activity, which included prescribing. We saw there had been multi-cycle audits aligned to the CQC searches. • Since our last inspection the practice had commenced a formal programme of prescribing and consultation notes audit of their clinical staff, including non-medical prescribers. • The practice regularly reviewed and discussed prescribing and data provided by the commissioners through the quality, performance and contracting dashboard. This data enabled the practice to benchmark their outcome data against other practices in their primary care network and in the wider Calderdale area. 	

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: <ul style="list-style-type: none">• Staff were encouraged and facilitated to complete all mandatory training identified by the practice. Staff told us they were given protected time to undertake their training.• At our previous inspection in March 2022, we found there were gaps in staff training uptake. At this inspection we saw that the practice had a mandatory training and frequency schedule in place for clinical and non-clinical staff. Training included safeguarding children and adults, mental capacity act (MCA), preventing radicalisation, infection prevention and control, basic life support, information governance, fire safety awareness, sepsis awareness and equality and diversity training.• We saw there were systems in place to monitor when mandatory training updates were due. At this inspection, we found staff training was up-to-date.• At our previous inspection there was no formal system in place for clinical oversight of non-medical prescribers. At this inspection we saw the practice had initiated a formal audit process of consultation notes and prescribing of their clinical staff, including non-medical prescribers.• There was a process in place for staff to receive a 3-month probationary review and an appraisal after one year. We saw all staff were up-to-date with their appraisal which included personal learning and development plans.• Staff told us support with revalidation processes was offered.	

Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes

Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff told us they worked closely with other local organisations and healthcare providers to ensure patients received care in a coordinated manner. This included the establishment of close working relationship with health visiting teams and palliative care teams. 	

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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff made use of consultations to opportunistically discuss health choices, provide supporting information and signposting to relevant services. The practice could refer to health and wellbeing coaches and care coordinators which helped patients improve their health, wellbeing and social welfare by connecting them to community services. The practice encouraged a culture of self-help and self-management through health and promotional information available at the practice and links on their website. The practice participated in the Community Pharmacy Consultation Scheme which enabled staff to refer minor ailments to the local pharmacy. 	

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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence <ul style="list-style-type: none"> Clinicians we spoke with understood the requirements of legislation and guidance when considering consent and decision making. We saw that staff had undertaken Mental Capacity Act (MCA) and consent training. We reviewed a sample of patient records where DNACPR orders were in place. We found evidence of a patient discussion, agreement of reasons for the decision and confirmation whether or not the patient had capacity to consent to DNACPR. At our last inspection in March 2022, we found that systems for regular review of the DNACPR decisions were not in place. At this inspection we found the practice had undertaken a quarterly DNACPR audit of all practice and care home patients to review the last documented DNACPR decision. The practice planned to continue to audit DNACPR decisions to ensure they were still appropriate. Staff were aware of the need to request consent to share records in line with General Data Protection Regulation (GDPR) principles. 	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> On the day of the inspection, we observed that staff spoke with patients in a dignified and respectful manner. We received written feedback from 4 patients who all said they were treated with dignity, respect and compassion by staff. One patient told us they felt all practice staff did an amazing job in highly stressful circumstances. We saw that staff had undertaken customer care training. 	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	83.9%	84.9%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	81.4%	83.4%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	92.6%	93.5%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	69.9%	70.7%	72.4%	No statistical variation

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

Any additional evidence

- As part of our inspection, we reviewed the outcomes of the recent National GP Patient Survey and the NHS Friends and Family Test (FFT).
- Overall, the outcome of the National GP Patient Survey was in line with local and England averages for patient experience in relation to the healthcare professional listening to them, treating them with care and concern, having confidence and trust, and involving them in decisions about their care and treatment.
- We received written feedback from 4 patients, 3 of whom had seen a clinician recently, and told us they felt involved in their care and treatment and felt like the clinician listened to them.
- We saw patients could access the FFT on the practice website and through a QR code displayed in the practice. We saw for the period June 2022 to June 2023 the practice had received 2,820 responses. We reviewed the responses and saw that 69% of patients would be very likely and somewhat likely to recommend the practice.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes

Staff helped patients and their carers find further information and access community and advocacy services.	Yes
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National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	93.6%	90.1%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice captured patient communication needs at the point of registration and through clinical consultations. We saw that the patient check-in system was available in several languages aligned to the practice demographic. Staff we spoke with knew how to access interpretation services, if required. We saw that the website had the functionality to translate to other languages. The practice had launched a new website which was more user-friendly and interactive. It included self-help portals to help patient manage their own health. 	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 205 on their carers' register, which was approximately 2.3% of the practice population. The practice was in the process of reviewing their carers register ahead of the influenza campaign to ensure all carers were captured and offered appointments.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> The practice told us they identified carers at the point of registration and on an ongoing basis through consultations. Information for carers was available on the practice website.
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> The practice told us that if a family had experienced a bereavement a GP would contact them to offer condolences.

	<ul style="list-style-type: none"> • The practice told us they would signpost patients to appropriate advice on bereavement support services. We saw information was also available on the practice website. • In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
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Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • On the day of the inspection, we observed confidentiality at the reception desk. We saw the computer on the reception desk was positioned so patients could not view the screen. • Staff we spoke with told us they followed the practice's confidentiality policy when discussing patients' treatments. This was to ensure that confidential information was kept private, for example, patient information was never on view and personal smart cards were removed when not in use. • We saw that all staff had undertaken privacy and dignity, information governance, and data protection training. 	

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

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

- Staff communicated with people in a way that they could understand. We saw communication aids, for example, an induction hearing loop.
- Staff had undertaken Accessible Information Access training.

Practice Opening Times

Day	Time
Opening times at main surgery:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Opening times at branch surgeries	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	CLOSED
<ul style="list-style-type: none"> • We saw that the branch surgeries were open 8am to 6.30pm Monday to Thursday. Appointments with a GP, practice nurse and healthcare assistant were available on Monday and Wednesday at 1 branch surgery and on Tuesday and Thursday morning at the other branch surgery. If a patient required an appointment on an alternative day, they could be seen at the main practice site. • Extended access appointments were provided collectively by the Primary Care Network (PCN). The practice was open on 1 Saturday in 4 on rotation with other practices in the PCN. Evening appointments were available from 6.30pm to 8pm at a local practice. • Out of hours care was available via NHS 111 or Local Care Direct. 	

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice told us they offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- The practice told us parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- The service was a 'veteran friendly' practice which was a national scheme to improve medical care and treatment for former members of the armed services. We saw information was available on the practice website.
- The practice was accredited to the 'Pride in Practice' programme to ensure that people from the lesbian, gay, bisexual and trans (LGBT) community have access to inclusive healthcare which meets their needs.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes
Patients were able to make appointments in a way which met their needs.	Yes
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised.	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice told us they constantly reviewed their access model to ensure that patients were able to make an appointment with the most appropriate member of their team. For example, GP, advanced clinical practitioner (ACP), practice nurse, healthcare assistant or pharmacist. • The practice offered access to telephone, face to face and online appointments at all 3 locations. Both pre-bookable and on the day appointments were available. • Online consultations were available from 7am to 12pm. These were triaged by a clinician on the same day and booked an appointment, where appropriate. The practice encouraged online booking to help reduce the potential delay for patients getting through on the telephone at peak times. • The practice operated a daily triage system from 8am to 10am at all 3 sites for urgent on the day queries or for those who could not access online consultations. These were triaged and called back the same day. • The telephone system included analytic software to enable the practice to monitor various call metrics, including call volume and wait times. 	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	57.1%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	46.7%	54.3%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	50.5%	55.0%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	71.4%	73.6%	71.9%	No statistical variation

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year (written and verbal).	34
Number of complaints we examined.	1
Number of complaints we examined that were satisfactorily handled in a timely way.	Yes
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice kept a log of written and verbal complaints to ensure all opportunities to learn from feedback was captured. We saw for the period July 2022 to June 2023 there had been 34 verbal and written complaints recorded and discussed. We saw complaints were discussed in meetings as a standing agenda item. 	

- There was a complaint policy, which was accessible to staff, written in line with recognised guidance.
- We saw all staff had received training in handling complaints.

Well-led

Rating: Good

At our inspection on 30 and 31 March 2022 we rated the provider as requires improvement for providing well-led care, as systems for oversight and governance of clinical and operational processes were not implemented.

At this inspection we found the provider had made improvements in the areas of concern found at our previous inspection. The provider is now rated good for providing a well-led service.

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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The leadership team had been responsive to the findings of our previous inspections in March and July 2022, and we have found continued improvement in systems and processes at this inspection to demonstrate safe, effective and well-led care. • The practice had an experienced leadership team in place, who understood both the local and national challenges to healthcare. They told us they continued to improve and adapt their service to ensure it could continue to provide effective care to their patients. 	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes

<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice told us their mission statement was, ‘to be dedicated to providing compassionate, caring services to the community we serve. Working in a professional manner with every patient, passionate about providing excellent, accessible and responsive care for all and committed to empowering our community of patients to live healthier lives.’ This was underpinned by their core values to be caring, accountable, fair and professional. We saw the practice’s vision and values statement was displayed within the practice and staff were aware.

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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Staff we spoke with were positive about working at the practice and said they felt supported by the clinical and administrative team. Staff told us the practice was friendly and everyone worked as a team. We saw all staff had undertaken whistleblowing and being open training. Not all staff we spoke with understood the term duty of candour. The practice told us that they would deliver duty of candour refresher training at the next practice meeting to improve staff awareness. We saw staff had undertaken bullying and harassment, and conflict resolution training. 	

Examples of feedback:

Source	Feedback
Staff interviews and staff questionnaires	<ul style="list-style-type: none"> We spoke with several members of staff during the inspection and received staff questionnaires. All staff stated they felt well supported and that there were good, effective working relationships between managers and staff. They told us they felt supported by the practice both professionally and personally. Staff we spoke with told us they had access to the equipment and training necessary to enable them to perform their roles well. We were told staff were given protected time to enable them to undertake training and carry

	<p>out non-clinical duties, checking fridge temperatures and emergency medical equipment.</p> <ul style="list-style-type: none"> • Staff told us they felt supported to develop in their roles. Some staff gave examples of how they had been supported in their career development. For example, a cleaner had been trained to become a receptionist.
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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
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • At our last rated inspection in March 2022, we identified gaps in some governance systems which included oversight of medicines management, medicines alerts, management of test results, staff training, and infection prevention and control. At this inspection we found the practice had addressed the areas of concern found at our previous inspection. • After this inspection the practice told us that to strengthen their governance systems and processes they had created automated reporting (batch reporting) in their clinical system for all the clinical searches undertaken at the inspection. They planned to run these monthly to ensure patients on certain medicines were monitored in line with guidance, including patients on medicines subject to safety alerts. • We saw that the management team facilitated communication within the practice through a formal meeting structure which included management, clinical, administrative and multidisciplinary team (MDT) meetings. Minutes of meetings were available for staff. • We saw staff used a secure social media platform to communicate news and updates. • The practice had nominated clinical leads for key areas, such as the safeguarding of adults and children and infection control, whom staff could contact for specialist advice and support. • Staff had access to policies, procedures and clinical protocols. All staff knew how to access these. • Staff we spoke with understood their individual roles and responsibilities and knew who to contact if further advice was required. 	

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

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

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.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Staff are supported to work remotely where applicable.	Yes

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.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice used a range of methods to gather patient feedback. For example, from the National GP Patient Survey, Friends and Family Test (FFT), complaints and compliments, and through the practice's Patient Participation Group (PPG).• The practice had an active PPG, who met quarterly and was attended by a GP partner and the practice manager.• We saw there was information on the practice website of how to join the PPG. The practice hoped to encourage more patients to join the PPG to make it more representative of the practice population.• We had feedback from several members of the PPG who were generally positive about their engagement with the practice. It was hoped that a practice newsletter would be re-introduced as a way of cascading information to patients.• Staff told us they could provide feedback through meetings, a staff feedback box, and their annual appraisal. Staff we spoke with felt the management team were approachable.	

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.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice engaged with neighbouring practices in local current and future initiatives which included the primary care network (PCN), which brings practices together on an area basis to strengthen and redesign primary care to focus on local population needs and provide care closer to patients' homes.• A range of data was collected and reviewed to improve service delivery and drive improved access, efficiencies and outcomes for the patient population. For example, we saw accurate and timely reviews of incidents, patient feedback, audits and patient outcomes such as prescribing.• Learning from significant events and audits was shared internally and externally to drive improvement in safe and effective care.	

- The practice engaged positively with the CQC inspection and made improvements to governance, clinical and prescribing systems and processes since our last rated inspection in March 2022.

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 SICBL 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 SICBL 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.