

Care Quality Commission

Inspection Evidence Table

Wayside Medical Practice (1-5518212640)

Inspection date: 17–22 November 2022

Date of data download: 01/11/2022

Overall rating: Good

At our previous inspections in September 2021, we rated the practice as requires improvement. This was because we found breaches of regulation in the Safe, Effective and Well Led domains.

At this inspection we found the practice had made significant improvements. Breaches of regulation had been reviewed and processes changed or improved to ensure systems and processes were working as needed. We saw evidence of performance and risk management with governance processes reviewed and clearly set out. These were understood by all staff and monitored for their effectiveness.

Safe

Rating: Good

At our previous inspection the practice was rated as requires improvement because:

- The system for recording and acting on safety alerts was not always effective.
- Test results were not always followed up appropriately in order to diagnose long-term conditions. For example, diabetes
- Staff did not always have the information they needed to deliver safe care and treatment.

At this inspection we found:

- Safety alerts were now well managed and there was an effective system in place. Any patients affected by safety alerts were contacted and their care discussed as required.
- All test results were followed up as needed and results recorded onto patient records. Our review of the clinical system did not show any areas of concern.
- Staff had the information they needed to deliver safe care and treatment.

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.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y

Safeguarding	Y/N/Partial
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>All staff had the required training for safeguarding. Staff we spoke with told us policies were accessible and the lead was knowledgeable and supportive if they needed to report any concerns. The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.</p> <p>Staff gave us examples where they had raised concerns over patient safeguarding which had been taken seriously and acted upon.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection we found:</p> <ul style="list-style-type: none"> • Staff had not received immunisation appropriate to their role nor in line with current UK Health Security Agency (UKHSA) guidance. • The practice did not record centrally staff immunisation status. <p>At this inspection we found:</p> <ul style="list-style-type: none"> • The staff immunisation policy was up to date and held clear information in relation to which staff required what immunisation and how the practice would mitigate any risks. • Staff immunisation was clearly recorded and aligned with current guidance. • All staff had received the required immunisations. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
There was a fire procedure.	Y
Actions from fire risk assessment were identified and completed.	Y

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.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit:	
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
All staff had completed training for infection prevention and control as well as hand hygiene. Staff we spoke with told us of ways in which they protected themselves from possible infection risks, and personal protective equipment was always available.	
The lead practice nurse undertook regular audits and ensured staff were up to date with the most recent guidance and information. They told us twice a year they used a powder that glowed under a UV light. This was placed in 10 high use areas around the building. The following day the same areas were checked for effectiveness of cleaning. It was noted at the last audit the top of bins within a toilet area still held a slight residue although the floor was clear. This was highlighted to the cleaning team to ensure bins were cleaned more thoroughly.	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
Explanation of any answers and additional evidence:	
Staff we spoke with were able to articulate what red flag symptoms meant and what actions they would take should they encounter them from patients. Sepsis and red flag symptoms information was readily available for reception staff.	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection, we found:</p> <ul style="list-style-type: none">Our searches indicated individual care records did not always provide an accurate and complete record. For example, clinical searches indicated 3 patients potentially had a missed diagnosis of diabetes. A further 3 patients records did not include the condition for which their medicine was being prescribed for. Coding for 4 patients did not include significant medical conditions such as diabetes, dementia and asthma found in the patient notes. <p>At this inspection we found:</p> <ul style="list-style-type: none">Our review of patient records in relation to clinical searches found information was now recorded appropriately to support their safe care and treatment. Test results were reviewed by doctors and any diagnosis was being appropriately recorded in a timely manner. <p>The practice was aware during the process of moving from their old clinical system to their new clinical system, that some patients had their diagnosis codes incorrectly mapped to the new system. During our searches we found a few patient records where their diagnosis had not been coded onto the new system. However, we saw patients had been safely monitored, and their care managed within current guidance. Examinations, medicine reviews and safety netting were all in place. We therefore had no concerns over the management of patients we reviewed during our searches. The practice had an action plan as to how they were reviewing patient diagnosis coding to align with their medical condition.</p>	

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 average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.63	0.73	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	7.8%	9.9%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	7.78	5.95	5.31	Variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	78.1‰	76.1‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.31	0.70	0.59	Tending towards variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	5.6‰	5.4‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y

Medicines management	Y/N/Partial
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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>At our previous inspection, we found:</p> <ul style="list-style-type: none"> • Prescription stationery was not always securely stored. Tracking sheets for prescription stationary contained out of date policies and procedures. • There was an ineffective process for monitoring patients' health in relation to the use of medicines including high risk medicines. • 2 out of 25 patients prescribed a medicine to treat inflammatory conditions, such as rheumatoid arthritis, did not have the appropriate monitoring and clinical review within the recommended time frame. For one patient there was no alert on their clinical record to demonstrate they were being prescribed a high-risk medicine. • 2 out of 8 patients who had been prescribed another medicine used to treat inflammatory conditions, did not have the appropriate monitoring and clinical review within the recommended time frame. • From a review of 3 patients prescribed a mood stabilising medicine, 1 patient had not had their body mass index checked since 2015. The records for another patient indicated they had not had a thyroid function test or calcium levels checked since April 2019. • 19 out of 46 patients prescribed blood thinning medicines, had not had appropriate monitoring and clinical review. 5 patient records reviewed found none had essential tests and calculations undertaken within the recommended time frame. • 14 out of 15 patients prescribed medicines prescribed for heart failure, appropriate monitoring and clinical review had not been undertaken within recommended time frames. We looked at the records of 5 patients, none had received blood tests within the recommended time frame before prescribing. All 5 patients had other significant medical conditions, some of which were not coded in the notes, for example dementia and asthma. <p>At this inspection, we found:</p> <ul style="list-style-type: none"> • Prescription stationery was securely stored. Policies were up to date and accessible to staff. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> Patients prescribed medicines to treat inflammatory conditions such as rheumatoid arthritis, had the appropriate monitoring and clinical review within the recommended time frame. Patient records we reviewed showed that patients prescribed a mood stabilising medicine, had received the correct monitoring. Patients prescribed blood thinning medicines, had received appropriate monitoring and clinical review. Patients prescribed medicines for heart failure, had received appropriate monitoring and clinical review within recommended time frames. <p>The practice was aware some patients' diagnosis conditions had not been coded on to the new clinical system due to the change between the old and new systems. The practice had an action plan as to how they were reviewing patient diagnosis coding to align with their medical condition.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	7
Number of events that required action:	7
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection, we found:</p> <ul style="list-style-type: none"> The practice kept records of each individual significant events. However, they did not keep an ongoing log of events to enable action to be monitored and trends identified. <p>At this inspection, we found:</p> <ul style="list-style-type: none"> Significant events were recorded onto the practice data system. This allowed for all events to be recorded in one place and an ongoing log of all events recorded. This ensured the practice could monitor trends. All significant events were discussed at practice meetings. Staff we spoke with told us this was an open discussion and ideas were welcomed on how to improve to ensure events were not repeated. They told us there was a 'no blame' culture. Details of significant events discussions were minuted to allow staff members not present at the meeting to understand the nature of the incident, the discussion and any actions taken or required. 	

Example of significant events recorded and actions by the practice.

Event	Specific action taken
Repeat prescribing error	Patient updated Pharmacist completed a full medicines review A full check of the repeat prescriptions and changes made as required

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection, we found:</p> <ul style="list-style-type: none"> Clinical searches identified the practice's system was not effective for ensuring compliance with all relevant patient safety alerts issued. For example, a Medicines and Healthcare products Regulatory Agency (MHRA) alert in December 2014 advised against prescribing a drug combination. Our searches identified 6 patients on this drug combination and none of them had received appropriate medication reviews and the combination switched at the appropriate time. There was no evidence to show safety alerts were discussed at practice meetings. <p>At this inspection, we found:</p> <ul style="list-style-type: none"> The practice had a protocol in place for actioning safety alerts. Alerts were disseminated to the required members of the team and where action was required, searches were conducted of clinical records to identify patients who may be affected. From a sample of patients' records we reviewed, we found action had been taken on all recent alerts, and systems ensured the provider continued to audit medicines previously subject to safety alerts, to ensure prescribing continued to be in line with up to date guidance. We saw evidence of discussions had in relation to safety alerts at practice meetings. 	

Effective

Rating: Good

At our previous inspection the practice was rated as requires improvement because:

- Insufficient progress had been made against indicators for the management of long-term conditions. Patients needs were not always assessed, and care and treatment was not always delivered in line with current guidance.

At this inspection, we found:

- Our clinical searches of patient records indicated care and treatment was delivered in line with current guidance. This included the management of long-term conditions.

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.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	
At our previous inspection, we found: <ul style="list-style-type: none">Clinical searches indicated 3 patients potentially had a missed diagnosis of diabetes.Appropriate health monitoring for high-risk medicines had not always taken place within recommended time frames prior to prescribing.	

At this inspection we found:

- Clinical searches indicated potentially 5 patients had a missed diagnosis of diabetes. However, when we reviewed those patients' records, we found 3 of the patients did not have a diagnosis for diabetes after further tests. The other 2 patients were newly diagnosed and had appointments booked to discuss their condition.
- Our clinical searches found patient care and treatment in relation to high-risk medicines was regularly reviewed and monitored. Appropriate health monitoring had taken place within recommended time frames prior to prescribing,

Effective care for the practice population

Findings

- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated 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.

Management of people with long term conditions

Findings

- 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 cardio-vascular 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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	84	87	96.6%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	77	79	97.5%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	77	79	97.5%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	77	79	97.5%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	59	64	92.2%	Met 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 had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.

The practice was aware of an issue with the historic coding of MMR vaccinations which impacted the data when transferred from their old patient system to their new system. This meant the number recorded was incorrect and more children under 5 had received their MMR vaccine. The practice was working with the Integrated Care Board to recode appropriately.

Cancer Indicators	Practice	SICBL average	England average	England comparison
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 persons aged 50 to 64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)	72.3%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	66.0%	62.5%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	73.8%	69.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	73.1%	56.8%	55.4%	No statistical variation

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.

Any additional evidence or comments
<p>The practice continued to review the uptake of cervical screening. Nurses ran cervical screening clinics, as well as providing ad hoc cervical screening. The practice contacted eligible patients for cervical screening via a letter and a phone call to influence patients to attend their appointments. Non-attenders were flagged on the patient's record so the screening test could be discussed opportunistically. The practice was able to offer evening and Saturday appointments.</p> <p>We noted the uptake of cervical screening had improved from our last inspection September 2021 from 70.7% to 72.3%</p>

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

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

Any additional evidence or comments
We found there was a programme of clinical audit. For example, there were audits of prescribing and medicines management audits undertaken. Audits had also been completed for oral nutritional supplements, a medicine to treat sleeping problems and a diabetic sensor patch.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: Online training was available for staff members, who told us they could complete this during their working day where possible or it was completed in their own time. Reminders were sent if training was due which allowed staff to plan their time accordingly to ensure training was completed in a timely fashion. Staff we spoke with told us how the practice was supportive of training and development to meet the needs of the service.	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence: Vulnerable patients were discussed at the Primary Care Network (PCN) wide multi-disciplinary team (MDT) meetings.	

Helping patients to live healthier lives

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

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

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Y
Explanation of any answers and additional evidence: Staff supported patients to live healthier lives. There was a focus on early identification and prevention and on supporting patients to improve their health and wellbeing.	

Responsive

Rating: Good

The data and evidence we reviewed in relation to the responsive key question as part of this inspection did not suggest we needed to review the rating for responsive at this time. Responsive remains rated as Good.

Access to the service

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

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Explanation of any answers and additional evidence: The practice website was up-to-date and included information about how to book an appointment, what to do in an emergency or when the practice was closed. The website included information about a range of local community-based services and services to which patients could self-refer. Patients could request repeat medicines and appointments via online services. The practice visited a nursing home with a GP, pharmacist and the primary care network co-ordinator. This ensured residents received clinical and holistic care as required.	

Well-led

Rating: Good

At our previous inspection, the practice was rated as requires improvement because:

- Concerns raised at our previous two inspections in relation to the monitoring of high-risk medicines had not been sufficiently addressed.
- Systems and processes were not operating as leaders intended. For example, the system for recording and acting on safety alerts.
- Accurate and complete records in relation to patients were not always maintained.

At this inspection, we found:

- The practice had reviewed processes for the monitoring of high-risk medicines. Our remote clinical searches did not indicate any concerns with patient monitoring or the safety netting of these patients.
- Governance systems were in place and working as intended. We saw evidence to demonstrate leaders had oversight of processes put in place.
- The practice had recently changed clinical systems. Most patient records we reviewed held complete and accurate information. The practice was aware of an issue when transferring data from the old clinical system to the new clinical system. There was an action plan in place to resolve this issue.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
At our previous inspection, we found: <ul style="list-style-type: none">• Leaders lacked oversight of some processes and therefore failed to identify risks when those processes did not operate as intended.	
At this inspection, we found: <ul style="list-style-type: none">• Leaders had ensured actions required were working as intended and was monitoring their effectiveness. There was an understanding of what the challenges were, and leaders had put actions in place to address them.	
The practice worked with the local practices within the primary care network (PCN) to understand local challenges to quality and sustainability to develop services. (PCNs have the potential to benefit patients by offering improved access and extending the range of services available to them, and by helping to integrate primary care with wider health and community services).	

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.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	
The practice held regular meetings to update staff with practice development plans.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	
Staff feedback was extremely positive. Staff told us they felt supported and respected. They told us ideas and suggestions were always welcome and their welfare was a priority for the practice. Staff told us of a no blame culture and an open-door policy. Managers within the practice told us of ways in which they supported staff, and this was evidenced from feedback we received.	
All staff were aware of a Freedom to Speak Up Guardian and told us they would be confident and supported to speak up. The Freedom to Speak Up Guardian was an external person outside of the practice but within the PCN.	

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

Source	Feedback
Staff interviews via Teams meetings. Face to face	Staff members we spoke with during the inspection reflected positively on the culture within the practice. They told us managers and GPs were approachable. Many staff had worked at the practice for a number of years and reported there

conversations. Staff questionnaires via email.	was a strong team ethos. Staff members commented positively on the opportunities to learn and develop. We were told ideas and suggestions were welcomed by leaders and we heard of examples where suggestions had been acted upon.
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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.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence:	
At our previous inspection, we found: <ul style="list-style-type: none"> The overall governance arrangements were not working sufficiently to ensure the management of risks, performance and other issues were being addressed. For example, the monitoring of high-risk medicines and safety alerts. At this inspection, we found: <ul style="list-style-type: none"> The practice had made improvements, and processes had been put in place to ensure systems were working as intended. We saw evidence to demonstrate governance systems had been reviewed and were now more effective. For example, the monitoring of patients on high risk medicines and effectively managing safety alerts. 	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
At our previous inspection, we found: <ul style="list-style-type: none"> Insufficient improvements had been made to the monitoring of patients on high risk medicines. 	

- Ineffective arrangements for identifying and managing the risks related to safety alerts.

At this inspection, we found:

- We saw evidence to demonstrate improvement had been made on the monitoring of patients on high risk medicines.
- Safety alerts were now effectively managed.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
<p>At our previous inspection, we found:</p> <ul style="list-style-type: none"> • Clinical searches showed the practice did not always maintain accurate and complete patient information. • Accurate and updated management records were not always maintained. For example, training records, or an overall record of staff immunisation <p>At this inspection, we found:</p> <ul style="list-style-type: none"> • Our review of the clinical system showed patients were well managed and patient records contained accurate information. The practice was aware of an issue when transferring data from the old clinical system to the new clinical system. There was an action plan in place to correct patient diagnosis coding to align with their medical condition. • The practice had reviewed governance systems to ensure they were effective. Leaders had oversight to ensure processes were working as intended. This included the recording of staff training and staff immunisation. 	

Governance and oversight of remote services

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

Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
The practice did not have an active patient participation group (PPG) due to poor interest since COVID-19 pandemic. As an alternative, the practice sought patient views through their website and through Friends and Family feedback. The practice manager informed us they were planning to reinstate the PPG with help from the PCN and they were looking at different and new avenues for patient feedback.	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
The practice continued to review ways of working to improve access. Through the PCN the practice had access to paramedic practitioners, practice pharmacists, and physiotherapist to improve the patient experience. The practice had access to social prescribing through East Surrey Wellbeing Prescription. (Social prescribing services, like Wellbeing Prescription, allow health care professionals and other professionals in local services to refer and signpost patients to a wellbeing advisor, who will work with clients to improve their health and wellbeing).	
The practice had links with East Surrey Domestic Abuse Services and a PCN wide frailty hub for the vulnerable elderly.	

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

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.