

Inspection Evidence Table

Westcroft Health Centre

(1-1155049766)

Inspection Date: 24/11/2022

Date of data download: 21/11/2022

Overall rating: Good

Safe

Rating: Requires improvement

We rated the practice as requires improvement for providing safe services because:

- Not all staff had completed training relevant to their roles, including safeguarding training.
- The practice did not have an adequate fire risk assessment in place.
- An infection prevention and control audit had not been undertaken.
- Systems for the appropriate and safe use of medicines, including medicines optimisation and the management of long-term conditions, were not always effective.
- The system to receive, review and take appropriate action on Medicines and Healthcare products Regulatory Authority (MHRA) safety alerts was not always effective.

Safety systems and processes

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

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.	Partial
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	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: The practice had practice specific safeguarding policies which were easily accessible to all staff members. All of the staff we spoke with demonstrated an awareness of managing safeguarding concerns.</p> <p>At the time of our inspection, we found some clinical and non-clinical staff members had not completed safeguarding adults and safeguarding children training to the appropriate level for their role. Staff had access to safeguarding e-learning modules and the practice told us that they had taken action to ensure all outstanding safeguarding training would be completed by all relevant clinical and non-clinical staff members.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence: We reviewed five staff personnel files and found gaps in reference checks in two of these files. The practice told us they would take mitigating actions in response to this.</p> <p>The practice had a comprehensive and effective system in place to ensure staff vaccinations were maintained and recorded in line with national guidance.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: 18/11/2022	
There was a fire procedure.	Y
Date of fire risk assessment: 09/05/2022	
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence: There was a record of portable appliance testing and equipment calibration by a competent person. The practice had a fire procedure and evacuation plan in place. The practice had fire wardens and all non-clinical staff members had completed fire safety training. During our inspection we found two clinical staff members had not completed fire safety training. The practice had a record of fire extinguisher checks, fire drills, fire alarm servicing and weekly testing. A fire risk assessment had been undertaken in 2014, however not all of the recommendations identified in this assessment had been acted upon and monitored. The practice had completed a fire risk assessment checklist in May 2022, however this had been completed by a former member of staff and the practice was unable to evidence that this individual was sufficiently trained and competent to undertake a fire risk assessment for the premises. Shortly after our</p>	

inspection, the practice told us an external contractor was scheduled to undertake a fire risk assessment on 8 December 2022 and we saw evidence confirming this.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not always met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out.	N
Date of last infection prevention and control audit: March 2020 (incomplete)	
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence: During our inspection, we found the practice to be clean and tidy. The infection prevention and control (IPC) lead completed an environmental cleanliness checklist on a weekly basis and the practice had acted on issues identified from these checks. The practice had commenced an IPC audit in March 2020 however this had not been completed. We found the practice had not undertaken any further IPC audits since March 2020 and the IPC lead had not completed IPC training. At the time of our inspection, records showed non-clinical staff members and two salaried GPs had not completed IPC training.</p> <p>Shortly after our inspection, the practice told us non-clinical staff and the IPC lead would be completing the required training for their role and an IPC audit would be carried out over the coming weeks. The practice also told us training gaps for salaried GPs was due to these GPs being newly qualified and the practice was in the process of obtaining their training certificates from their training provider.</p>	

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.	Partial
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
<p>Explanation of any answers and additional evidence: At the time of our inspection, the practice did not have records of basic life support training for all clinical and non-clinical staff members. The practice advised us clinical staff had attended face to face basic life support the day before our inspection and non-attenders were booked in for an additional training session planned for January 2023.</p>	

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

Appropriate and safe use of medicines

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

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) (01/10/2021 to 30/09/2022) (NHSBSA)	0.49	0.82	0.82	Variation (positive)
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). (01/10/2021 to 30/09/2022) (NHSBSA)	7.7%	8.7%	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)	5.22	5.52	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	74.4‰	99.7‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related	0.41	0.70	0.58	No statistical variation

Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)				
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	3.8‰	6.9‰	6.8‰	Tending towards variation (positive)

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 effective medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. 2	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
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence: The practice had systems and processes in place to support the safe prescribing of medicines in most cases. During our checks we found 173 patients were prescribed a medicine to treat epilepsy and nerve pain, however 67 of these patients did not have a record of	

an appropriate review. In response to our findings, the practice told us they were in the process of contacting all of the relevant patients.

We looked at the management of patients prescribed disease modifying anti-rheumatic drugs (DMARD). From the records we reviewed, we found patients had received appropriate monitoring. During our checks we looked at the system for managing patients prescribed a direct oral anticoagulant medicine and found these patients had received appropriate monitoring.

Track record on safety and lessons learned and improvements made

The practice had a system to learn and make improvements when things went wrong. However, not all safety alerts had been acted on or appropriately reviewed.

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:	15
Number of events that required action:	5
Explanation of any answers and additional evidence: There was an effective system in place for reporting and recording incidents and significant events. The staff we spoke with were clear on the reporting process used at the practice and we found that lessons learnt were shared to make sure action was taken to improve safety in the practice.	

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

Event	Specific action taken
An out of hours report was assigned to the named GP who was not working on the day it was assigned to them.	All staff were reminded to follow the practice protocol and assign out of hours reports to the duty doctor if the named GP is not working.
Vitamin D prescribing error.	Learning needs were addressed and the current prescribing guidance/formulary for Vitamin D was displayed in all clinical rooms.

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

Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence: We saw a process was in place for the receipt, review and monitoring of action taken in response to safety alerts including Medicines and Healthcare products Regulatory Agency (MHRA) alerts. We saw examples of actions taken in response to recent alerts, including one regarding sodium valproate (a medicine primarily used in the treatment of epilepsy). However, during our checks we found the practice had not taken the required action for 4 patients in response to a safety alert issued in April 2022. The practice took immediate action and told us they had contacted all relevant patients and were making the necessary changes for these patients where appropriate.</p>	

Effective

Rating: Good

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 had prioritised care for their most clinically vulnerable patients during the pandemic	Y
The practice prioritised care for their most clinically vulnerable patients	Y
Explanation of any answers and additional evidence: The practice assessed needs and delivered care in line with relevant and current evidence-based guidance and standards. The practice had systems in place to keep all clinical staff up-to-date. Staff had access to National Institute for Health and Care Excellence (NICE) best practice guidelines and online tools and templates. They used this information to deliver care and treatment that met patients' needs.	

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.
- Frailty assessments were offered to patients over 75 years of age.
- At risk patients were provided with a fast track telephone number to contact the practice.
- 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 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.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. There were 78 patients on the practice's learning disability register at the time of our inspection. All those aged 14 years and over had been invited for a health check and over 90% of these patients had received a health check within the previous 12 months.
- 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.

Management of people with long term conditions

Findings

- We found patients with a diagnosis of chronic kidney disease were being appropriately managed. However, during our checks we found 110 patients with blood tests indicating they may have an undiagnosed chronic kidney disease which had not been documented in their records. During our inspection, senior clinicians advised us that they were taken action in response to this and were developing a plan to review these patients.
- We found the practice was pro-active in identifying potential undiagnosed diabetes and carried out targeted work to effectively manage patients with diabetes.
- During our inspection we looked at a sample of records of five out of 30 patients diagnosed with Asthma, with two or more courses of rescue steroids prescribed in the last 12 months. One patient record did not include documented evidence of an adequate asthma review within the previous 12 months. We also identified three patient cases where there was no documented evidence that emergency steroid cards had been issued, in line with guidance by NHS England and the August 2020 National Patient Safety Alert Steroid Emergency Card, to support early recognition and treatment of adrenal crisis. During our inspection the practice took immediate action and introduced a new protocol to ensure steroid cards would now be routinely issued.
- In most cases, patients with long-term conditions were offered an effective 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.
- 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.

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)	159	169	94.1%	Met 90% minimum

The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) <small>(NHS England and Improvement)</small>	154	166	92.8%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) <small>(NHS England and Improvement)</small>	156	166	94.0%	Met 90% minimum
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) <small>(NHS England and Improvement)</small>	156	166	94.0%	Met 90% minimum
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) <small>(NHS England and Improvement)</small>	199	226	88.1%	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
Childhood immunisation uptake rates were about the national minimum target of 90% for four out of five indicators. The practice investigated their performance for the percentage of children aged 5 who had received immunisation for measles, mumps and rubella and told us current unverified data showed they had now achieved 90.8%. The practice advised us they were unable to read code those patients who had declined this vaccination and some overseas patients had their immunisations at different ages compared with the schedule in England, which would also affect the recorded performance. The practice also explained they were awaiting vaccination records for newly registered patients.

Cancer Indicators	Practice	SICBL average	England	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). (30/06/2022 to 30/06/2022) <small>(UKHSA)</small>	71.0%	N/A	80.0%	Below 80% target
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) <small>(UKHSA)</small>	60.5%	57.3%	55.4%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) <small>(UKHSA)</small>	72.5%	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)	68.5%	64.0%	66.8%	N/A
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Any additional evidence or comments

We spoke with practice staff about their efforts to achieve 80% attainment for cervical screening (the threshold set for the National Health Service Cervical Screening Programme to be effective). We found the practice operated a reminder system for patients who did not attend for their cervical screening test. They demonstrated how they encouraged uptake of the screening programme, for example, by ensuring a female sample taker was available. The practice had made changes to the appointment system in an attempt to increase uptake and were planning on increasing the number of nurse appointments available for cervical screening, following the recruitment of a nurse who was due to join the nursing team in January 2023.

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
<p>We looked at the details of two clinical audits completed over the past year. These were full cycle (repeated) audits or part of a full cycle programme (scheduled to be repeated) where the data was analysed and clinically discussed, and the practice approach was reviewed and modified as a result when necessary. Findings were used by the practice to improve services.</p> <p>The practice completed an audit to check the monitoring of patients prescribed a disease modifying anti-rheumatic medicine. The initial audit showed that 39% out of 38 patients were being appropriately monitored in adherence with national guidelines. The results were clinically discussed and a set of recommendations were agreed and implemented. The results from the repeat audit showed all of the patients being prescribed this medicine were being appropriately monitored.</p> <p>The practice undertook an audit on the uptake of Long Acting Reversible Contraception (LARC). The initial audit showed 303 out of 910 patients (33%) had been started on a LARC. Recommendations from the initial audit were implemented and the repeat audit showed 443 out of 819 patients (39%) had been started on a LARC. This was an increase of 6% in the number of suitable patients being started on a LARC.</p>	

Effective staffing

The practice was able to demonstrate in most cases 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.	Partial
Staff had protected time for learning and development.	Partial
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.	Partial
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
<p>Explanation of any answers and additional evidence: Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included role-specific training and updates for relevant staff, the use of online training and locally held training days.</p> <p>During our inspection, we found some clinical and non-clinical staff members had not completed training relevant to their roles, such as safeguarding children and adults, fire safety, infection prevention and basic life support. The practice told us they would take immediate action to ensure all staff completed training relevant to their roles.</p> <p>The practice had a clear system in place for the induction and review of new employees and all but one staff member had received an appraisal within the previous 12 months. The practice told us the outstanding appraisal would be completed within the coming weeks.</p>	

Coordinating care and treatment

Staff worked 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.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
<p>Explanation of any answers and additional evidence: The practice worked closely with a multi-disciplinary rapid response service in place to support older people and others with long-term or complex conditions to remain at home rather than going into hospital or residential care.</p>	

The practice provided care and treatment services to residents with a learning disability at two local care homes.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. We saw evidence that multi-disciplinary team meetings to discuss the needs of complex patients, including those with end of life care needs, took place on a regular basis.

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
Explanation of any answers and additional evidence: The practice referred patients to a local weight management scheme and were also able to refer patients to a dietician employed through the local Primary Care Network (PCN). A Primary Care Network is a group of practices working together to provide more coordinated and integrated healthcare to patients).	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence: We saw the process for seeking consent was well adhered to and examples of documented informed patient consent for recent procedures completed at the practice were available.	

Well-led

Rating: Good

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: Senior leaders had plans in place to split the practice management role and re-define individual senior roles and responsibilities to better manage and mitigate risks and overarching governance.	

Vision and strategy

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

	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 strategy was supported by the delivery of high quality and sustainable care in most cases.	

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.	Partial
<p>Explanation of any answers and additional evidence: Staff feedback was positive about the culture and openness within the practice. The Patient Participation Group (PPG) and staff were involved in discussions about how to run and develop the practice and were encouraged to identify opportunities to improve the services delivered by the practice.</p> <p>During our inspection, we found not all clinical and non-clinical staff members had completed equality and diversity training.</p>	

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

Source	Feedback
Staff interviews	The staff members we spoke with told us that there was a good relationship with managers and they could raise concerns and report when things went wrong. Staff were positive about the culture and their working environment and told us they felt respected, valued and well supported.

Governance arrangements

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

	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
<p>Explanation of any answers and additional evidence: The practice had a regular schedule of meetings in place for all staff members including multi-disciplinary teams. Clinical oversight and accountability within the practice had been established. There was an overarching governance framework in place and staff had access to practice specific policies. At the time of our inspection, we found the practice did not have an adequate system in place to ensure all staff members had completed the appropriate training relevant to their roles.</p>	

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Managing risks, issues and performance

The practice had clear and effective processes for managing risks, issues and performance in most cases.

	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.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence: The GP partners monitored clinical performance and had developed an emergency plan to effectively manage patients with diabetes during a period of low staffing within the nursing team. Clinicians regularly reviewed the systems and processes in place for the safe and effective management of patients with long-term conditions.</p> <p>At the time of our inspection, we found the practice had not taken adequate actions to effectively manage all aspects of fire safety, infection prevention and control, medicines which required monitoring and safety alerts.</p>	

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
<p>Explanation of any answers and additional evidence: We found the practice used accurate and reliable data and indicators to understand and monitor the performance of the practice. There was a programme of clinical and internal audit which was used to monitor quality and to make improvements.</p>	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y

The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
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.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence: The staff we spoke with said they were encouraged to actively participate in practice life and share their views. An open culture among staff and management supported this.</p> <p>We saw there were various methods available for patients to express their views and leave feedback about their experiences. Information about how to make a complaint or raise concerns was available and it was easy to do. The practice offered apologies to patients, lessons were learnt from individual concerns and complaints and action was taken as a result to improve the quality of care.</p>	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y

Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: The practice worked closely with other practices within the locality and were involved in a health inequalities initiative through the local PCN. One of the GP Partners had attended a course on developing the practice into a more environmentally friendly service and was in the process of forming a working group to take this forward. The practice had plans to improve messaging and patient information by using prescriptions to promote health outcomes and reduce wastage. The practice had identified the need to reduce the reliance on prescribing hypnotic medicines and were in the process of signing up to an online app which had been developed to help people improve their ability to sleep.	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands. The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ‰ = per thousand.