

Care Quality Commission

Inspection Evidence Table

Guildowns Group Practice (1-544213010)

Inspection date: 25 – 28 July 2022

Date of data download: 06 July 2022

Overall rating: Good

At our previous inspection in September 2021, we rated the practice as requires improvement. This was because we found breaches of regulation in the safe and well-led key questions.

At this inspection we found the practice, had taken on board all of the concerns raised at the last inspection. For example, patients' medicines management was now effective, staff had received the required vaccinations, the four sites were working consistently, staff feedback was extremely positive and risks were being well managed.

Safe

Rating: Good

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

- There were areas of medicines management that were not sufficient.
- There was insufficient evidence that staff vaccination was maintained in line with current guidance.
- There were gaps in arrangements to assess, monitor and manage risks.
- The management of patient safety alerts were not sufficient.

At this inspection we found:

- Medicines management was working effectively.
- Staff vaccination was maintained in line with current guidance and individual risk assessments were in place where results were pending.
- Risks were well managed and the practice had systems to monitor compliance and the action required.
- Patient safety alerts were handled effectively including historical alerts.

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

Safeguarding	Y/N/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:</p> <p>At our previous inspection we found:</p> <p>The safeguarding contact sheets in reception areas and clinical rooms contained an out of date email address for the single point of access local safeguarding team.</p> <p>At this inspection we found:</p> <p>Safeguarding details were correct on all of the contact sheets situated around the four locations. We spoke with the safeguarding administration lead. Their role was to ensure all documentation was up to date and support the safeguarding leads.</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> <p>Two GPs did not have a record of their vaccinations. Other records we reviewed did not always have sufficient evidence of vaccination. We saw that staff were asked to complete a disclaimer regarding their immunisation status however this did not align with the current guidance.</p> <p>At this inspection we found:</p> <p>Staff vaccination was clearly recorded and aligned with current guidance. Where staff were waiting for confirmation of their vaccine status a risk assessment had taken place. The risk assessment reviewed risk to the staff member, patients and other staff members and if there was a requirement to change the staff members role to reduce risk.</p>	

Safety systems and records	Y/N/Partial
<p>Health and safety risk assessments had been carried out and appropriate actions taken.</p> <p>Date of last assessment:</p> <p>Wodeland Surgery: 13/6/2022</p> <p>The Student Health Centre: 10/06/2022</p> <p>The Oaks Surgery: 09/06/2022</p> <p>Stoughton Road Surgery: 16/05/2022</p>	Y

There was a fire procedure.	Y
Date of fire risk assessment: Wodeland Surgery: 05/07/2022 The Student Health Centre: 05/07/2022 The Oaks Surgery: 05/07/2022 Stoughton Road Surgery: 05/07/2022 Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: We saw evidence of a health and safety tracker. This was a document which listing the required health and safety checks needing to be completed by the practice, weekly, monthly, quarterly, six monthly and annually. We saw this was kept up to date and included dates of when completed, by whom and any actions that were required.	

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. Date of last infection prevention and control audit: 25/05/2022	Y
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: At our previous inspection we found: Infection prevention and control (IPC) audits and action plans were not being completed consistently across the sites. For example, in the IPC audits for two sites, areas that were compliant were marked with a tick and non-compliant areas were marked with a cross. However, in the IPC audits for the other two sites only crosses were used. We also noted that the dates for completion for the mitigating actions were not all specific to the priority of the action but were set for the date of the next IPC audit. The waste management company had been unable to supply the correct sharps safes at some of the sites. This information had not been shared widely and no risk assessment had been completed to identify and mitigate this risk. At this inspection we found: The practice was using a single IPC audit tool which recorded information for all of the locations. Any concerns found were recorded in an action plan. This included the action required, the person responsible and the date for completion. At this inspection sharp bins had been correctly delivered by the waste management company and were being used as intended. Any risks identified from the IPC audit were being tracked and monitored.	

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

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 last inspection we found:</p> <p>Multiple codes were in use for patients receiving palliative care .</p> <p>At this inspection we found:</p> <p>The practice had reviewed the codes used for patients receiving palliative care and was ensuring that clinicians were using the same code. This was evidenced when we reviewed the practices clinical system.</p>	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.76	0.71	0.79	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). (01/04/2021 to 31/03/2022) (NHSBSA)	7.3%	10.3%	8.8%	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 (01/10/2021 to 31/03/2022) (NHSBSA)	5.33	5.90	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	90.7‰	76.3‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	1.00	0.71	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	7.9‰	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

Medicines management	Y/N/Partial
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.	n/a
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	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
<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 showed that nine out of 16 patients prescribed a disease-modifying antirheumatic drug (DMARD) may not have been monitored appropriately. We reviewed five individual patient records and found that all these patients had received all required blood test monitoring appropriately. We noted that four of the five records did not contain up to date recordings for either weight or blood pressure. • Our searches showed that 16 out of 43 patients prescribed a particular medicine used to treat fluid retention may not have been monitored appropriately. We reviewed five individual patient records and found that monitoring blood tests or review were overdue for all five patients. One patient was only a few days overdue their monitoring tests but the other four were between two and four months overdue. • Our searches showed that there were 16 patients who may have a potential missed diagnosis of diabetes. We reviewed five individual patient records and found that four had not been coded for follow up appropriately. The fifth patient had not been coded or followed up appropriately. 	

Medicines management	Y/N/Partial
<p>Appropriate emergency medicines were available at each site. Staff we spoke with were not clear how to access the monitoring records for the site that they were working in. We also noted that some emergency medicines were stored away from the emergency trolleys, but it was not clear where each medicine could be found.</p> <p>At this inspection we found:</p> <ul style="list-style-type: none"> We reviewed three different kinds of disease-modifying antirheumatic drug (DMARD) and found all patients had received the appropriate monitoring. We reviewed five random patient records and found all had the required blood test monitoring and records contained up to date recordings for both weight and blood pressure. We completed searches for patients prescribed a particular medicine used to treat fluid retention and reviewed five patient records. We found that patients had been requested to attend for reviews and were being effectively monitored. We reviewed five patients records from 12 who may have had a missed diagnosis of diabetes. We found that all five patients had been coded correctly and were being monitored. <p>During our onsite inspection we reviewed the emergency medicines stored on trolleys at each of the four locations. We found that the emergency medicines stored on the trolleys were appropriate, were the same across the four sites and had been checked to ensure they were in date. Although there were medicines stored in locked cabinets these were in addition to those found in the emergency trolleys and all cabinets held the same medicines. Documentation for the emergency medicines was found on each of the trolleys. Staff we spoke with were aware of where the trolleys were situated and dedicated staff members were required to monitor stock levels and expiry dates.</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:	35
Number of events that required action:	35
<p>Explanation of any answers and additional evidence:</p> <p>We saw evidence that the practice was reviewing all of their significant events. We noted that an annual review had taken place to ensure continued learning and trend analysis. This meeting was also used to ensure any changes in place were working as intended.</p>	

Example of significant events recorded and actions by the practice.

Event	Specific action taken
Expired contraceptive coil – although date was checked it was written in American format and so incorrectly thought to be in date	Staff made aware of date format used. Administrative time was given to the healthcare assistant to check stock regularly. There was no risk to the patient.

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> <p>There was a system in place for recording and acting on new safety alerts. However, our searches found that the practice was not always prescribing in line with active safety alerts.</p> <ul style="list-style-type: none"> Our clinical searches found that xix patients who were prescribed a particular dose of a medicines which may significantly increase the risk of serious side effects in patients over a certain age. We reviewed five individual patient records and found no evidence in the patients' records that four of these patients had been informed of the risks or alternatives had been considered. The fifth patient was no longer taking this medicine. Our searches showed nine patients who were prescribed a particular combination of medicines which may significantly increase the risk of serious side effects. We reviewed five individual patient records and found no evidence in the patients' records that four of these patients had been informed of the risks or alternatives had been considered. The fifth patient was no longer taking this combination of medicines. <p>At this inspection we found:</p> <p>The practice had reviewed their system for monitoring safety alerts. We reviewed the same two safety alerts as our last inspection. We found that one patient had been prescribed one of the combination of medicines. This patient had been informed of the risks and was being monitoring. We found no concerns from the searches we conducted for safety alerts.</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

Effective care for the practice population

Findings
<p>The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. Health checks, including frailty assessments, were offered to patients over 75 years of age. Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group. The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.</p> <p>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.</p> <p>All patients with a learning disability were offered an annual health check.</p>

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

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)	126	132	95.5%	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)	155	169	91.7%	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) (NHS England and Improvement)	152	169	89.9%	Below 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) (NHS England and Improvement)	155	169	91.7%	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) (NHS England and Improvement)	166	208	79.8%	Below 80% uptake

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

Cancer Indicators	Practice	CCG 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: 31/12/2021) (UK Health and Security Agency)	61.6%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	69.3%	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)	67.6%	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)	64.6%	56.8%	55.4%	No statistical variation

Any additional evidence or comments

The practice continued to review the uptake of cervical screening. Nurses ran cervical screening clinics, as well as providing adhoc 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 that the screening test could be discussed opportunistically.

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 comprehensive programme of clinical audit and second cycle audits. For example, there were audits of prescribing and medicines management audits undertaken. We saw the practice had also undertaken audits for bowel cancer, high risk medicines and gestational diabetes.

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

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

Helping patients to live healthier lives

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

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

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y

Responsive

Rating: 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	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
<p>Explanation of any answers and additional evidence:</p> <p>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.</p> <p>The practice had created an Urgent Care Team. This meant that patients calling with urgent health issues, would be given a same or next day telephone appointment with this team. The team consisted of GPs, nurses and paramedics in order for patients to receive the best care. After the initial telephone consultation, face to face appointments were arranged for patients that required one.</p> <p>Patients calling with symptoms of an infectious condition, would be asked to visit a dedicated room at Wodeland Avenue Surgery.</p> <p>Non-urgent health issues and routine matters were offered the next available phone appointment.</p> <p>Patients could also request to book directly with a physio professional for muscle or joint problems, a mental health practitioner for wellbeing or emotional support, or a social prescribing link worker for complex social issues.</p>	

Well-led

Rating: Good

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

- Identification, management and mitigation of risk was not sufficient.
- Not all systems and processes were operating as leaders expected.

At this inspection we found:

- The practice has made significant improvement and addressed all of the concerns previously raised.
- Risks were identified and well managed. There was a robust approach to ensuring risks were reviewed and action taken in the required time frames.
- Systems and processes were regularly reviewed to ensure they were working as intended.

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">• The leaders in the service had identified high staff turnover as a significant challenge and had tried a number of approaches to recruit and retain staff. At the time of our inspection staff turnover was still high, particularly in the patient services team.• Staff feedback was mixed and showed that although most staff found senior leaders and GPs approachable, this was not the case for all levels of management.	
At this inspection we found:	
<ul style="list-style-type: none">• Staff turnover was low and most staff we spoke with told us they felt that levels of staffing in all areas were about right. They told us the work load was manageable and were happy with the internal changes made to incorporate more lead roles.• We received feedback from 18 staff members and spoke with staff during our interviews and onsite visits to the four sites. All staff we spoke with told that work morale was high. They told us that all staff, including GPs and leaders, were approachable and were happy to be contacted if needed. They told us they felt supported in their roles.	

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: At our previous inspection we found: <ul style="list-style-type: none">• There were elements of the practice vision where the strategy was outside the direct control of the practice, such as new buildings. The future planning with staff, patients and external partners had been started but at the time of our inspection was paused due to the COVID-19 pandemic.• Feedback from staff was mixed and although some staff felt engaged with the vision and strategy, others felt changes were imposed on them without any input from staff. At this inspection we found: <ul style="list-style-type: none">• The future planning of a new building was being developed and progression made.• Staff we spoke with felt engaged with the process of the vision and strategy. They told us that they felt their input was valued and where possible taken on board.	

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: At our previous inspection we found:	

- Staff feedback was mixed and although most staff told us they felt able to raise concerns, some staff felt they were not able to raise concerns safely or be assured they would be listened to.
- The business manager told us of an incident where a job had been externally advertised but internal staff had not been made aware. They were aware of the potential impact on staff well-being and had apologised for the error. However, they also noted that communication needed to be improved to avoid this happening again.

At this inspection we found:

- Staff feedback was extremely positive. Staff told us that they could raise concerns, questions or suggestions and that these would be listened to. They told us communication was a two way process and felt more involved with the running of the practice. Managers within the practice told us that staff well-being was a priority and sent weekly emails to all staff informing them of any changes within the practice and general updates. The email included links for further support if required and staff told us they appreciated this and felt able to speak with leaders, managers and GPs about any concerns they might have.

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

Source	Feedback
Staff interviews via Teams meetings.	Staff members told us there was a friendly and supportive environment to work in. They told us morale was high and all leaders, managers and GPs were approachable.
Face to face conversations.	Many staff had worked at the practice for a number of years and reported there was a strong team ethos. New staff members told us how they had felt support by the whole team.
Staff questionnaires via email.	Staff members commented positively on the opportunities to learn and develop. We were told that ideas and suggestions were welcomed by leaders and we heard of examples where suggestions had been acted upon.
	Staff members told us they felt communication had improved and that the additional leaders' roles had ensured the dissemination of important information.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
At our previous inspection we found:	
<ul style="list-style-type: none"> • We found that although improvements had been made since our inspection in December 2019 not all systems were operating as the leaders in the service intended. 	

At this inspection we found:

- The practice had made improvements, and process had been put in place to ensure systems were working as intended. Tracking sheets were used to ensure actions were reviewed and updated. These were regular reviewed by leaders and management.

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:

- Some systems and processes were still not operating as leaders in the services intended. For example; the monitoring records for emergency medicines for each site were not easily accessible to staff, staff vaccinations were not recorded sufficiently, not all policies contained up to date information. The practice's systems around repeat prescribing and the monitoring and management of high-risk medicines needed to be reviewed.
- Risk management systems were not effective.

At this inspection we found:

- Leaders had reviewed systems and processes and these were working effectively. For example, emergency medicine monitoring was easily accessible across the four sites. Staff vaccinations were recorded and up to date and where needed risk assessments were in place. Policies we reviewed contained up to date information. Repeat prescribing and the monitoring and management of high-risk medicines was working as effectively.
- We saw risk assessments in place across the four sites. These included an internal risk assessment and an external company risk assessment.

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

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

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

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had good uptake from staff in relation to their key training requirements and staff felt the practice was supportive of any learning and development needs.</p> <p>The practice had a programme of audits to review services and identify areas for improvement. Complaints and significant events were regularly discussed and used to support learning and improvement.</p> <p>There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and looked to develop in ways which supported their staff and the patient population. For example, appointing administration staff as leads in differing roles to help support clinical staff and patients.</p> <p>The practice was involved in a variety of initiatives including:</p> <ul style="list-style-type: none">• Diabetic Multi-Disciplinary Team pilot – monthly liaison between Primary Care Network practice leads and Royal Surrey Diabetes consultants and nurses.• First contact physio appointments spread across the week at three different sites, to improve access .• Family planning dedicated face to face appointments provided by family planning team across three sites.• Remote consultation and electronic prescribing service to local pharmacies for students who were back home for university holidays.• Urgent care team – able to address urgent care needs with same day multidisciplinary appointments.• GP Integrated Mental Health Service (GPiMHS) – piloted at Guildowns and now Surrey Heartlands wide. Self-referral is available via the practice website. (GPiMHS is an emotional and wellbeing service for adult patients over 18. Patients are offered extended consultation times, quick and easy access to practical advice and tailored support for their mental health needs from Mental Health Practitioners or Community Link Workers).	

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.