

# Care Quality Commission

## Inspection Evidence Table

### Whiteladies Medical Group (1-543622944)

Inspection date: 14 September 2022

Date of data download: 01 September 2022

We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

## Overall rating: Good

### Safe

Rating: Good

#### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>Senior leaders held a spreadsheet that allowed them to monitor staff training.</li><li>Staff were confident in safeguarding processes and how to access relevant information.</li></ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Copies of staff identification documents were not routinely held by the practice. The practice told us that documents had been viewed and verified as part of the induction process and demonstrated induction checklists which confirmed this.</li> <li>Staff vaccination records were viewed and held for clinical staff, however there was no oversight of non-clinical staff vaccination history and this had not been risk assessed. We discussed this with the practice who told us post inspection that these documents had been requested from staff and provided evidence that the induction checklist had been updated to include this information for future employees.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 1 September 2022	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 7 January 2022 Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice provided evidence of various health and safety risk assessments including a general risk assesment which covered all areas where actions had been identified. We saw onsite that some of these actions had been completed such as improved signage, the risk assessment had not been updated to reflect this completion.</p> <p>Following the fire risk assessment completed by an external agency, the practice had developed an action log. The action log demonstrated required changes had been made within recommended timeframes. However there were actions which were noted as recommendations from the risk assesment, which the practice had gauged as a priority to be completed within three and six months that were outstanding. These recommendations included:</p> <ul style="list-style-type: none"> <li>Due to paper storage, it is recommended that an automatic smoke detector should be fitted centrally in this room.</li> <li>It is recommended that occupiers of the building who share common areas supply a copy of their risk assessments.</li> </ul>	

We raised this with the practice who told us they were aware that some actions had not been completed as required. They told us that practice resources had been focused on other areas where perceived risk to patients was higher, such as access to appointments. For example, due to a shortage in reception and administration staff, senior practice leaders had spent time on reception answering calls and booking patients for appointments. Following the inspection the practice sent evidence that the items on the risk assessments would be completed and that outstanding actions had been started with dates of external agencies to attend the practice updated onto the action plan.

We saw evidence that fire alarm checks were completed weekly and that the practice carried out a planned full evacuation in line with guidance.

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 24 September 2021	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The most recent infection prevention and control (IPC) room audit was carried out in September 2021. We saw evidence of an audit that pre dated this with some outstanding actions. For example:</p> <ul style="list-style-type: none"> <li>• No overflow in the sink</li> <li>• No apron dispenser</li> <li>• Sharps bin placed too high.</li> </ul> <p>We discussed this with senior leaders and there had been a change of nurse manager during this time which had resulted in this oversight. During the inspection, we saw that some of these actions, such as replacement of apron holders and additional of waste bins, had been completed but not updated on the IPC audit action plan. Post inspection, we were provided with evidence that the practice was now compliant and the action plan reflected this. There was one outstanding action on hold, which was holes in a treatment room ceiling as future electrical work was due to be carried out. The practice told us that resources had been focused on other areas where perceived risk to patients was higher, such as access to appointments. This had led to the oversight of updating action plans.</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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Since the our last inspection in December 2015, the practice had made improvements to the storage of emergency medicines and carried out monthly checks on emergency equipment. During the inspection we found that the automated external defibrillation pads were out of date, however the practice acted on this immediately, ordering a new set to arrive the next day and attempted to source another set for the same day from a local practice.</li><li>• During the summer seasons, the practice employed medical students to support in administrative and some clinical assistant tasks to cover annual leave.</li></ul>	

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes

Explanation of any answers and additional evidence:

We conducted a remote review of the practice's clinical system prior to inspection and identified that in most cases test results were managed appropriately. However, we identified that there were 47 outstanding urgent test results of which 33 were over one week old. The oldest dated back to 8 June 2022 and had not been actioned as they had not been allocated to an appropriate person. We saw that 16 of the test results had been allocated to the 'duty doctor' work queue, however this was not monitored by a dedicated member of staff. We raised this with the practice and when we conducted our site visit on 14 September 2022 we saw the practice had actioned the test results as necessary. They had also identified necessary learning for staff which had been shared appropriately. A new process for administrative staff was also implemented to ensure GPs were held accountable for actioning urgent test results and mitigate the risk of this reoccurring.

## Appropriate and safe use of medicines

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

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

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) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.43	0.69	0.82	Significant 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). (01/07/2021 to 30/06/2022) (NHSBSA)	11.4%	9.2%	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 (01/10/2021 to 31/03/2022) (NHSBSA)	5.19	4.51	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	55.2‰	90.7‰	128.0‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.90	0.52	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	5.5‰	5.0‰	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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. <sup>1</sup>	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. <sup>2</sup>	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	NA
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<ul style="list-style-type: none"> <li>Blank prescriptions were kept in a locked cupboard with access limited to practice staff. Staff told us that when prescription stationary was required, they would take a small bundle from the box and once finished printing, would replace the ones that had not been used. However, the practice did not have oversight of this. There was no protocol for recording the movement of prescription forms including the recording of serial numbers. This meant the practice would be unable to identify if any blank prescriptions were unaccounted for. Following the inspection, the practice developed a new process that included a log sheet to record the date, time and serial numbers of blank prescriptions to record movement in line with guidance.</li> </ul>	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> <li>• The practice had completed an audit into the prescribing of oral morphine in line with the medicine safety project overseen by the integrated care board. The audit showed out of 44 patients, two had clear documentation in line with guidance. During the audit 18 patients were identified as no longer taking the medicine and all other patients were reviewed or notes updated to be clearly documented in line with guidance.</li> <li>• The practice held an emergency equipment trolley and an emergency bag in case of an emergency outside the practice. Both of these were regularly checked appropriate equipment held. However, the practice did not stock all suggested emergency medicines such as atropine (used for slow heart rates) and opiates (used for severe pain). There was no risk assessment to provide rationale why particular medicines were not being held at the practice. Post inspection, we were provided with an updated emergency medicines protocol, which detailed the rationale for the drugs they held.</li> <li>• During the remote clinical searches carried out by a CQC GP specialist advisor we found that out of 334 patients prescribed direct oral anticoagulants (a medicine that prevents blood clot formation to reduce the risk of strokes) 175 patients had not received the correct monitoring. Patients had received relevant blood test but the calculation of creatinine clearance (a marker for how quickly the body will excrete the medicine through the kidneys) was missing in these patients. We discussed this with the practice and when we conducted our site visit, they provided us with evidence that 90% of these patients since had their creatinine clearance calculated and had identified a learning need in some of their clinicians. A training document had been developed and circulated to the relevant members of staff.</li> <li>• We found that out of 107 patients prescribed gabapentinoids (medicine used to treat neuropathic pain and occasionally epilepsy), 22 had not received medication reviews in the last 12 months. We reviewed five of the 22 patients and found that four had evidence that the patients' response to the medication and dosage had been reviewed but there was not formal medication review for example, with the use of a template. None of the 22 patients had been coded as having received a medication review within the last 12 months. We highlighted this to senior leaders who recognised this could be improved. Practice data for the prescribing of this medicine was below local and national averages. They provided a quality improvement document they had been focusing on to help maintain positive prescribing practices.</li> </ul>	



## Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	5
Number of events that required action:	5
Explanation of any answers and additional evidence: Significant events were a standing agenda item on the monthly clinical team meeting. Staff felt able to raise a significant event without fear and were invited to contribute to the discussion of learning from events.	

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

Event	Specific action taken
Two patients were administered a second covid booster vaccine after already receiving it.	<ul style="list-style-type: none"> <li>• Error was acknowledged, patient and relatives were informed, apologies given.</li> <li>• Discussed at clinical meeting.</li> <li>• Information Technology (IT) team to cross reference outstanding patients who required boosters.</li> <li>• Planned review of administrative procedure.</li> <li>• Learning for clinical staff to check patient records including ability to consent before administration of vaccines.</li> </ul>
An E- consult submitted to the practice was not actioned until the patient recontacted the practice.	<ul style="list-style-type: none"> <li>• Error acknowledged and patient informed.</li> <li>• Apologies given.</li> <li>• Discussed at clinical and reception team meetings.</li> <li>• Discussion with all reception staff to review the process of managing E-consults.</li> </ul>



Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. <sup>1</sup>	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>During remote clinical searches carried out by a CQC GP specialist advisor, we looked at how the practice responded to safety alerts. We found that 13 out of 52 patients prescribed the medicine combination of Spironolactone or Eplerenone (medicines used to treat heart failure) plus an angiotensin receptor blocker (ARB) or angiotensin-converting enzyme (ACE) inhibitor (medicines used to treat high blood pressure) had not received blood monitoring in the last 6 months in line with guidance. The practice told us that the interval set on their recall system for these patients had been set incorrectly and was recalling them for monitoring every 12 months rather than every six months. When we conducted our site visit, the practice provided evidence that they had amended their recall system to ensure going forward, that these patients were invited for monitoring every six months.</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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>The practice had a primary care network (PCN) IT team who were responsible for medicine reviews and recall systems. Systems and processes allowed for updated protocols to be implemented with ease.</li></ul>	

## Effective care for the practice population

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check. Following a quality improvement project, these were now carried out by a named GP.
- 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.
- The practice encouraged personalised care plans through advanced planning.
- Musculo-skeletal physiotherapists were based at the practice and were accessible to registered patients.
- Patients could be referred to a social prescriber for alternative methods of support.
- Where secondary care requested changes in patient medication, this could be reviewed by clinical pharmacists and forwarded to their prescribing hub.
- Patients over the age of 75 received contact from a care coordinator following discharge from hospital.

## Management of people with long term conditions

### Findings

Remote clinical searches by a Care Quality Commission (CQC) GP specialist advisor for this inspection showed patients received appropriate monitoring of their health and received a clinical review for long term conditions in most cases.

The reviews included in our searches included patients diagnosed with:

- Asthma who had had two or more courses of rescue steroids in the last year.
- Chronic kidney disease stage four or five, which is a reduction in kidney function, structural damage or both.
- Hypothyroidism, a condition where the thyroid gland does not produce enough hormones.
- Diabetic retinopathy whose latest HbA1C result was more than 74mmol/l. Diabetic retinopathy is a complication affecting vision that can arise in people diagnosed with diabetes. HbA1c is a blood test that can give a picture of someone's blood glucose levels over the previous two to three months and therefore an indication of the management of their diabetes.
- We found that out of 470 patients diagnosed with hypothyroidism, 42 had not received the correct monitoring. We discussed this with the practice and during the inspection process the practice provided us with evidence that these patients had since received the correct monitoring or a further reminder had been sent out for them to attend the practice. The practice also added this to their month of birth recall system.

Other findings include:

- 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.
- 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.
- The practice attend a quarterly virtual diabetic clinic between practice nurses and secondary care team to ensure best care for their patients.
- 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.
- In house spirometry appointments were held for respiratory patients.
- Improved access to care for diabetes patients who are housebound, which is to be adopted into a full time role by the Integrated Care Board.
- There was a GP dementia lead who reviews patients holistically and supports multi agency working for these patients.

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)	73	74	98.6%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	94	96	97.9%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	95	96	99.0%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	93	96	96.9%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	93	97	95.9%	Met 95% WHO based target

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

#### Any additional evidence or comments

The practice offered parents and children coordinated same day appointments for post-natal checks, eight week baby check and first immunisation appointment.

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: 31/03/2022) (UK Health and Security Agency)	73.7%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	71.7%	61.4%	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)	68.4%	66.7%	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)	42.9%	58.4%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments
We discussed with senior leaders that the practice is not currently meeting the 80% target for cervical screening. We were told that the practice had previously held allocated sessions for cervical screening, however they had continued to have poor uptake. The practice told us that some of the challenges they faced included practice list reviews, informed patient refusal, and coding. They recognised this was an area to continue to improve on but noted a need to currently prioritise higher risks including patient access.

## Monitoring care and treatment

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

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

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

- The practice completed a medicines optimisation prescribing quality scheme that looked into heart failure. The practice reviewed their patients to ensure they were on the appropriate medication and were following the most up to date guidance.
- Following poor uptake of learning disability health checks and a late diagnosis for a patient with learning disabilities, the practice reviewed their current process for completing the health and medication checks. The practice implemented the following changes for patients with a learning disability; health and medication checks being carried out by the patients named GP, feedback questionnaires being sent to the patient, implementing improved recall systems and information available on patient notes. When the practice re-audited, they found some patients had not been contacted over the winter period, so they re-organised some of their tasking. The practice remained committed to improve care for patients with a learning disability.
- The practice is involved in multiple research projects including; surveillance of COVID-19 in patients receiving blood tests, EMBRACE (which is aimed at patients over 60 to reduce the risk of developing E-Coli), Milestone (a study into non medicinal alternative to treating depression).



## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>Staff have routinely had access to appraisals on an annual basis. Due to recent demand, the practice had suspended these until October to optimise patients access. Staff were aware of this and had booked in their delayed annual appraisal. Staff reported an open culture and felt able to raise concerns or learning needs with senior leaders earlier if needed.</li><li>The practice offered a chaperone service. At the time of inspection, no staff members had completed chaperone training. We discussed this with senior leaders who told us they had had difficulty accessing training. As a result, they only allowed health care professionals to chaperone as they perceived this group of staff to have the necessary knowledge to chaperone safely. Since the inspection, the practice organised for all healthcare assistants, nurses and selected reception staff to receive this training. The training is due to be completed by the end of October 2022.</li></ul>	

## 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.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>The practice displayed a variety of healthy living posters in their waiting room, including; mental health helplines, domestic violence and pregnancy advice. There was access to social events including the clifton garden society. The practice also displayed current research projects they were involved in and patients had access to drinking water.</li><li>The practice had access to a social prescriber to support patients' individual needs.</li></ul>	

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence, including from clinical searches: We reviewed do not attempt cardio pulmonary resuscitation (DNACPR) decisions which were recorded in patients' clinical records. The practice used ReSPECT forms (documentation to support patients to make anticipatory decisions including resuscitation) to record these decisions in line with local guidance. We reviewed five patients' ReSPECT forms and found that whilst rationale to implement the DNACPR and discussions with the patients and relatives were in line with guidance, the rationale was not always clearly documented on the ReSPECT form. We discussed this with senior leaders, who explained that all clinicians that would require access to patient notes for this information do so and therefore would be able to see the reasons for these decisions. The practice were in the process of transferring ReSPECT forms onto a new system and therefore would review the summary of decision in patients with a DNACPR.	

## Responsive

Rating: Not rated

### 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 minimize the length of time people waited for care, treatment or advice	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Data demonstrates that the practice was meeting national averages for access to GP services.</li><li>• 82% of patients were satisfied with the appointment they were offered.</li><li>• The practice told us they were aware of the gaps in administrative staff. They had been actively recruiting and reviewed pay scales for administrative staff to aid in the recruitment and retention of staff.</li><li>• The practice had redeployed staff to support reception when required to ensure patients were able to access appointments in a timely way.</li></ul>	

## Well-led

**Rating: Good**

- The practice has been rated good for providing well led services as although there were some minor areas where improvements could be made the practice demonstrated a culture of learning and following our feedback instantly made the required changes.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>Senior leaders have recognised the national challenge in maintaining practice partnership and retention of GP's. As a result they had employed two new practice partners to safeguard them for the future.</li><li>To aid the recruitment and retention of the administrative staff in the practice, senior leaders had conducted a pay review and increased the salary for this group of staff. Senior leaders reported they wanted to ensure staff felt valued.</li><li>The practice communicated regularly with other practices in their primary care network (PCN) to provide support for one another. They had a central IT team and shared some clinical staff across the PCN.</li></ul>	

### Vision and strategy

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

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

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Once a month, the practice offered free lunches funded by the PCN for all members of staff.</li> <li>Staff meetings were held every morning for all members of staff. Following the meeting, staff were encouraged to partake in stretching and breathing exercises that was completed as a team. Staff reported they enjoyed starting the day with this.</li> </ul>	

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

Source	Feedback
Staff questionnaires and interviews.	Themes of feedback we received were: <ul style="list-style-type: none"> <li>Open culture.</li> <li>Positive team work and supportive colleagues.</li> <li>Staff felt listened too.</li> <li>There were known gaps in staffing particularly in administrative tasks, however there was an awareness that this was being addressed.</li> <li>Staff were supported to learn and progress.</li> <li>Staff felt senior leaders were proactive in promoting change and learning.</li> <li>Most staff felt management were open and transparent and provided good communication.</li> </ul>

## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: The practice was part of a primary care network (PCN) and worked collaboratively with them. For example, staff sharing arrangements and exchanging ideas.	

## 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.	Partial
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: We found practice processes were not always effective, for example: <ul style="list-style-type: none"><li>• Clinical searches highlighted medicine reviews and high risk drug monitoring recall systems and staff education required improvements.</li><li>• Systems did not always ensure patients with long term conditions had their care reviewed in line with guidance.</li><li>• An error in allocation of test results had gone unnoticed, which revealed learning needs and requirement for new protocol.</li><li>• Risk assessments were carried out, however actions were not always followed up within the perimeters set.</li><li>• Protocols for emergency medicines and blank prescription safety required updating to be in line with guidance.</li><li>• Induction checklists required updating to prompt the collection non clinical staff vaccination records.</li></ul>	

The practice was receptive to feedback upon any areas where improvements could be made which demonstrated a culture of learning and improvement. Shortly after the post inspection feedback the practice were able to evidence the necessary actions were taken to improve safety for patients. Actions included:

- Updated protocols, systems and processes such as birth month patient recall.
- Reviewed action plans and outcomes.
- Identification of learning needs and planned training.
- Recall of affected patients.

We found some of the oversights for updating actions were due to recognition of higher risks such as improving patient flow and access. The need to deploy resources had paused daily tasks, however oversight was resumed once the risk lowered.

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Staff members were provided with laptops to allow them to work remotely when COVID-19 pandemic restrictions would have otherwise prevented them from working.</li> <li>• The practice had improved patient access for flu vaccination clinics. Clinics were held on the first floor and utilised a one way system to avoid large groups of patients in one area.</li> </ul>	



## Appropriate and accurate information

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

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

## Governance and oversight of remote services

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

## Engagement with patients, the public, staff and external partners

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

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

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"><li>• We spoke with the patient participation group (PPG), who told us since the pandemic, they had been meeting using online video services quarterly to ensure communication remained open.</li><li>• During the meetings there were opportunities to ask questions and that key members of the practice's senior leadership attended.</li><li>• The PPG felt consulted regarding changes occurring at the practice and they felt valued.</li><li>• Meetings were minuted and placed on the website for all patients to view.</li></ul>

## Continuous improvement and innovation

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

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

## Examples of continuous learning and improvement

<ul style="list-style-type: none"><li>• The practice had a healthcare assistant completing nursing associate training.</li><li>• There was a strong focus on research and development in the practice including; COVID-19 blood monitoring, Milestone (a study into non medicinal alternative to treating depression).</li><li>• At the time of inspection, one of the nurses was funded by the Queens Nurses Institute to pilot an innovation in care. They were half way through the project that was aimed at improving care for housebound diabetic patients. The success of this had led to the Integrated Care Board (ICB) funding a full time diabetic nurse to cover this workload.</li><li>• A GP senior leader had been awarded trainer of the year for year one and two medical students.</li><li>• Where community services were facing challenges, the practice ensured nursing associates were given working time to support the registered patients to avoid unnecessary hospital admission.</li></ul>
---

## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.