

Care Quality Commission

Inspection Evidence Table

Oakside Surgery (1-550838487)

Inspection date: 23 March 2022

Date of data download: 28 March 2022

Overall rating: Good

Safe

Rating: Good

At the previous inspection in August 2021, the practice was rated as Requires Improvement for the provision of safe services due to lack of reassurance surrounding infection control and responding to safety alerts.

- There was no clear safeguarding process in place and not all staff were up to date with safeguarding training appropriate to their role. Safeguarding meetings were not held.
- Processes to ensure medicines requiring refrigeration have been stored in line with manufacturers' guidelines were not in place.
- Recruitment processes were not always safe, some pre-employment checks had not been undertaken.

At this inspection, we saw evidence of required improvements from the last inspection:

- All staff were trained to appropriate levels of safeguarding,
- Infection prevention and control audits had been carried out and findings acted upon,
- Medicines were stored and monitored in line with manufacturers guidelines with management systems in place should a breach occur,
- Recruitment processes now had verified documents with pre employment checks.

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"> Since the last inspection training information provided by the practice showed clinicians had now been trained to level three safeguarding children as recommended by the intercollegiate guidance for child safeguarding published in January 2019. 	

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 Public Health England (PHE) guidance if relevant to role.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Since the last inspection, the practice was able to demonstrate an improved level of governance around recruitment procedures. This included the regular checks of current registrations for clinicians. However, while individual documentation was available, some of this information was stored across more than one computer system. This meant recruitment records were not always available on demand or organised into a single point of access. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 30 July 2021	Yes
There was a fire procedure. Date of fire risk assessment: 2 August 2021	Yes
Actions from fire risk assessment were identified and completed.	Yes

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: 14 March 2022	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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice had completed a full infection prevention and control audit. An annual plan had been documented and approved. This set out the practice's ongoing goals to improve and maintain levels of infection prevention and control.	

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">Since the last inspection, all staff had received Immediate Life Support (ILS) training, including staff on zero-hours contracts. ILS is a certificate above the required Basic Life Support (BLS) level of training, meaning staff were better prepared to support patients who present as acutely unwell or are deteriorating.The reception staff had protocols for managing acutely unwell or deteriorating patients.Staff told us they felt supported in seeking advice from clinical staff when concerned about a patient's health.	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results, and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• On the day of our inspection, we checked the practice's pathology inbox and all results had been allocated. The provider told us pathology results were actioned daily.• Arrangements were in place to ensure staff were familiar with the process of reviewing and allocating the pathology cases in the case of staff absences.	

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) (01/01/2021 to 31/12/2021) (NHS Business Service Authority - NHSBSA)	1.01	0.75	0.76	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). (01/01/2021 to 31/12/2021) (NHSBSA)	7.4%	9.5%	9.2%	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 (01/07/2021 to 31/12/2021) (NHSBSA)	5.49	5.71	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	243.3‰	142.7‰	129.2‰	Tending towards variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) (NHSBSA)	1.36	0.75	0.62	Tending towards variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	8.0‰	7.5‰	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.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes

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.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England 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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Non-medical prescribers and nurses had access to daily support from GP's, however there was no formal / documented process for assessing the prescribing competencies of non-medical prescribers. • We explored the practice's use of Pregabalin and Gabapentin (medicines used for nerve pain, epilepsy and anxiety) and hypnotic medicines. The practice had a higher than usual number of patients who have complex substance misuse and mental health conditions. The practice had been working with the lead pharmacists and these patients in a programme of reducing the prescribing of these medicines with fortnightly reviews. • A new medicine fridge had been purchased and an up to date cold chain protocol was in place. • We saw evidence of a protocol to manage any breach in the storage of medicines process and the actions the provider would take. • Regular fridge temperature monitoring took place this included daily checks and the use of internal fridge temperature monitoring devices which were downloaded weekly, sooner if a concern arose. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	4
Number of events that required action:	1
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these subjects were discussed. We saw evidence that lessons were shared, and action was taken to improve safety in the practice. For example, in one incident we could see where further staff training was required to improve understanding and competency. We could see from the evidence supplied how incidents were shared during meetings and where appropriate lessons learned were covered in these meetings with staff. 	

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

Event	Specific action taken
Fraudulent prescription claim of a controlled drug.	The practice alerted relevant authorities. A serious incident was reported, and an investigation began. Learning outcomes were shared and discussed across the practice. The practice reviewed repeat prescribing and medication policy.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> All clinical staff had access to safety alert information. Alerts were discussed at weekly practice meetings to ensure all relevant staff were aware and able to take action. The pharmacist completed audits to ensure the changes had been made. 	

Effective

Rating: Good

At the previous inspection in August 2021 we rated this key question as Requires Improvement for providing effective services because

- Staff training was not effectively monitored
- Not all staff were up to date with mandatory training,
- Not all staff received annual appraisals,
- Consent was not always recorded in the patient's notes prior to receiving treatment.

At this inspection we saw evidence of required improvements from the last inspection:

- Systems were in place to monitor and ensure staff had completed mandatory training,
- There was a process in place for staff to undergo annual appraisals,
- Consent being sought and documented prior to treatment being received, forms had been completed with the patient prior to minor operations and scanned onto the records, templates were used for vaccinations and other procedures.

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">• The practice had a triage hub operated daily by Advanced Nurse Practitioners (ANPs) and paramedics. The hub triages e-consultations and patients accessing the practice, directing them to the most suitable person for their needs. This allows patients to receive timely care from the appropriate clinician. The hub is supported by the duty doctor.	

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.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was an appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- 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.
- The practice shared clear and accurate information with relevant professionals when deciding on 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 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)	28	82	34.1%	Below 80% uptake
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)	75	92	81.5%	Below 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)	74	92	80.4%	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)	75	92	81.5%	Below 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)	95	107	88.8%	Below 90% minimum

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

Any additional evidence or comments
<ul style="list-style-type: none"> The practice had not met the minimum target for childhood immunisation in all five immunisation uptake indicators. The practice informed us this was due to a sudden high level of non-attenders (at the previous inspection the practice had met the 90% minimum target. Historical Care Quality Commission inspections have found the provider had met its childhood immunisation targets). The practice had explored the reasons for the decrease in uptake for childhood immunisations during this period. A combination of recent social media misinformation which reinforced vaccine hesitancy and immunisation confidence, had potentially impacted these figures. An education campaign for mums to be, including new mums were spoken with when attending the practice discussing current thoughts and concerns on immunisations to help build understanding and confidence in childhood vaccines. The practice was able to evidence more recent figures for childhood immunisations (our data is a snapshot from March 2021) the evidence showed the practice had improved in encouraging uptake in- <ul style="list-style-type: none"> Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) was 85% (as opposed to the 34.1% shown above). This significant improvement

gave evidence that the practice's campaign to improve uptake was leading to an improved uptake in childhood immunisations.

- The practice continued to work to improve numbers for the remaining childhood immunisations.

- The practice demonstrated insight of reduced uptake for childhood immunisation and had arranged a meeting with Public Health England and was liaising with the Health Visiting Team to look at ways to increase uptake.
- The practice was in regular communication with the childhood immunisation team. This was to ensure ongoing attempts to contact non-attenders and encourage uptake.
- Non-attenders and non-responders were followed up via phone, text or letter.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The provider was looking to recruit further practice nurses and develop the nursing team for childhood immunisations.

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 30/09/2021) (Public Health England)	69.7%	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) (PHE)	63.1%	66.5%	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) (PHE)	65.0%	71.4%	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) (PHE)	43.9%	56.6%	55.4%	No statistical variation

Any additional evidence or comments

- The practice was able to evidence more up to date figures for the percentage of women eligible for cervical cancer screening (our data is a snapshot from March 2021) the evidence showed the practice had improved in encouraging uptake. The most recent data shows the practice was at 81% (from 69.7%) now exceeding the England average.

- The practice recognised the reduction in uptake for cervical screening. The practice had a dedicated staff member who arranged appointments for cervical screening. Nursing staff had offered Saturday morning clinics to cater for working people. A letter and texts are sent to eligible patients as reminders to attend their appointments.

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 continued to identify that their level of prescribing for Pregabalin and Gabapentin was higher than the CCG average. They had been reviewing all patients who were being prescribed gabapentinoids. The practice contacted patients with the information regarding the side effects and risks of these drugs and how they were able to provide support to reduce or stop them. The practice used various methods to contact these patients through text, telephone or letter, with ongoing attempts to contact hard to reach patients. The practice recognised many of this patient group fell into hard to a reach category through being socially disadvantaged, e.g. homelessness and had taken effective steps to ensure ongoing attempts to engage. Ongoing support was delivered with fortnightly reviews with this patient group.

They identified the following three groups:

- Those on a low dose, were more amenable to rapid cessation with support.
- Those on mid-range doses, would need a plan of reduction and support.
- Those on a higher dose, would require assistance from another provider, such as a specialist addiction service.

The practice focused on the low and the mid-dose group working along with further clinical support, from a psychiatrist or GP input. As a result of this approach, the number of patients on gabapentin continued to reduce. Those on a higher dose were referred and supported with a local addiction and rehabilitation services as required.

The practice worked closely with the local substance mis-use and addiction service, the practice understood complex patients often had mental health and polypharmacy (patients' multiple medications) risks. Regular monthly meetings were held with this service and the practice to review and support those patients. The practice could also contact this service if a patient was in crisis. This helped ensure they developed care plans appropriately and in a timely manner.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Partial
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.	Partial
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">• Not all staff felt able to access training during work hours due to the demands on their role. However, we were told by staff additional time could be agreed with managers and claimed back.• We saw evidence that an appraisal programme was in place for all staff. All staff had undergone an appraisal in the last 12 months (this excludes staff who are new to the practice).• While Advanced Nurse Practitioners had on going daily support from GPs. The provider told us that there is a process in place for assuring the prescribing competencies of non-medical prescribers, but this was not documented.	

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-centered 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

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 Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">We saw evidence of consent being sought and documented prior to treatment being received. Forms had been completed with the patient prior to minor operations and scanned onto the records, consent templates were used for vaccinations and other procedures.	

Well-led

Rating: Requires Improvement

At the previous inspection in August 2021 the practice was rated as Requires Improvement for this key question, because

- The culture did not effectively support high-quality sustainable care and the overall governance arrangements were ineffective.
- The practice did not have clear and effective processes for managing risk, issues and performance.

At this inspection we rated the practice as Requires Improvement again, however progress had been made.

- The practice continues to consist of a sole GP and a non-clinical supporting partner; however, the provider demonstrated a plan to develop the partnership to ensure more clinical sustainability for the future.
- The management structure had been reviewed and whilst governance processes continue to need to be embedded the practice was working to achieve this.
- The practice was aware of its limitations in meeting the patient need and had developed services with allied health professionals to enhance services.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	No
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• The partnership consisted of a sole GP and a non-clinical supporting partner; a succession plan was not in place. There was also no documented plan in place for how or who would take oversight of the clinical operations should the sole GP be suddenly taken ill and unable to support the practice for a period of time. This put the practice at risk for continuity of patient care and delivery of services.• Leaders were aware of the challenges faced with staffing at present and the demands this placed on delivering care. There were plans in place to address these through recruitment but at the time of inspection these had not been completed.• Since the last inspection the practice had appointed an operation manager and deputy practice manager. Both these roles, while experienced in general practice, required further experience to embed within the practice leadership structure.	

Vision and strategy

The practice had a clear vision, but it was not supported by a 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.	Partial
Progress against delivery of the strategy was monitored.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had drawn up a new strategy, however, this was in its infancy and work towards delivering against it was limited. The strategy itself was so new that effective analysis into developing progress against its targets had not yet been established. While short and medium term milestones were covered the lack of formalised senior management meetings at the time of inspection meant we were not assured that progress delivery against the strategy was effectively monitored. Being a new strategy it will take time to embed into the practice where staff at all levels could see how their work helps drive the practice strategy forward. While staff knew the vision and values of the practice, staff had not yet had sight of the newly revised strategy and were unable to understand their role in helping to achieve its goals. 	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behavior 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
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff told they felt able to raise concerns with the management team and that they felt listened to. 	

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

Source	Feedback
CQC Staff feedback forms	<p>The overall theme from staff feedback forms collected was positive. Staff stated they enjoyed working for the practice. An increase in staff meetings had led to staff feeling more involved in the day to day issues facing the practice.</p> <p>Challenges did remain in finding enough staff to cover an increasingly busy practice. However, staff felt leaders were aware of the challenges facing staffing and were acting to improve this.</p>

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.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At our last inspection we found the following: <ul style="list-style-type: none"> The practice did not have an overarching governance framework that supported the delivery of the strategy and good quality care. These included: Systems and processes were not in place to ensure effective oversight of significant events and learning or improving the service as a result of these. Systems to ensure safe recruitment processes were not following safe recruitment procedures. Systems to ensure processes that checked clinical staff continuing registration on national registers were not in place. This meant patients could be at risk of being treated by staff who were not qualified to fulfil their role. The systems and processes for monitoring training were not effective and did not ensure an up to date record of staff training was maintained. This placed patients at risk of potential harm. Area of training not systematically recorded included; <ul style="list-style-type: none"> Safeguarding Infection Control Health and Safety At this inspection, we found the practice had improved in all areas related to managing and developing its governance arrangements. We were shown evidence that demonstrated systems and procedures that addressed the shortcomings found during the previous inspection. 	

- Work continued to improve and consolidate recruitment files into a single system for ease for recalling documentation.

However

- While we recognised efforts to make improvements since the last inspection, development of governance procedures were not fully embedded. For example, Advanced Nurse Practitioners' ongoing competencies required formal oversight of the lead GP. However, due to recruitment challenges the lead GP was unable to perform this fundamental role to support clinicians. The lead GP is aware of this and has plans to improve overall governance.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Due to two partners leaving, the practice faced challenges with a capacity to lead effectively. This had led to service delivery being reactive and mostly focused on short term issues. This is in part down to ongoing demands to service delivery as the practice moves out of the pandemic. • A limited quality improvement process was in place. Due to pressures on the service through the pandemic the practice diverted attention to more critical services to manage emerging patient risks. This meant a holistic programme of quality improvement had yet to be adopted as the practice moves out of pandemic conditions. 	

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

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The advanced nurse practitioner carried out regular audits of minor surgery and cytology using this to improve the service. Staff were aware of the decline in performance around cervical screening and childhood immunisation and had put plans in place to work with organisations to address this. 	

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.	Partial
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The development of the Patient Participation Group (PPG) had been paused during the pandemic. Low community interest in becoming a member had also impacted the number of members. The practice told us they were developing new ways to improve uptake and interest for patients to become members of the group. For example, a change in language used to promote interest in the PPG empowering locals to get involved to help shape the future of the practice and their care. 	

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.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	

- Since the previous inspection learning and improvement had developed within the service and formed an integral part of the quality assurance processes. There was a culture of learning when things went wrong, and all staff understood the processes for this. We could see from meeting minutes how information was shared, and changes made.

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.
- **PHE:** Public Health England.
- **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.
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- ‰ = per thousand.