

Care Quality Commission

Inspection Evidence Table

Watership Down Health (1-547895396)

Inspection date: 18 to 26 April 2022

Date of data download: 19 April 2022

Overall rating: Good

At the previous inspection in January 2019, the practice was rated as requires improvement and we found areas of non-compliance with the Health and Social Care Act Regulations (HSCA) 2014. This was in relation to medicines management and security, staff training and staff development and we issued requirement notices in respect of Regulation 17 of the HSCA (Good Governance) and Regulation 18 (Staffing). We rated Safe, Effective and Well-led as Requires improvement.

Following our recent inspection in April 2022, we found the practice had addressed the areas of non-compliance with regulations. We rated the practice Good overall and Good for Effective and Well-Led. We carried over the Good ratings for Caring and Responsive from the 2019 inspection.

Safe

Rating: Good

At our last inspection in January 2019, we rated Safe as Requires Improvement. This was because:

- The practice's process to ensure actions from risk assessments were carried out, was not consistent and did not give assurances that all risks to patient safety were mitigated.
- Medicine fridge temperatures and stock levels for emergency medicines were not monitored consistently and effectively.
- Stock cupboards which held medical equipment were not always secure.
- The process for recording and acting on Medicines and Healthcare products Regulatory Agency (MHRA) alerts was not consistent and actions taken were not always recorded appropriately.
- Blank prescriptions were not logged in and out of clinical rooms to ensure stock levels were accurate.
- The practice did not have oversight of staff training and could not be assured that all staff had received training appropriate to their role.

At this inspection, we found:

- All actions raised from risk assessments had been checked and completed.
- Fridge temperature logs had been reviewed by managers and lead practice nurses and key points reiterated to staff. These were now appropriately monitored.
- Emergency medicine stock levels had been reviewed and a process put in place to monitor them.
- The practices MHRA procedure had been reviewed and updated.

- Prescription stationary was stored securely and there was a process in place to record stock, in line with current guidance.
- All staff had undertaken training appropriate to their role and there was a system in place to ensure that renewal dates were flagged to both staff and managers.

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
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in January 2019 the practice did not have proper oversight of staff training. For example, there was no record of safeguarding adults training for a healthcare assistant and a practice nurse.</p> <ul style="list-style-type: none"> • At this inspection we saw evidence that all staff were trained in line with guidance and the practice's policies. Staff we spoke with knew the practice's safeguarding lead and where to find contact details for local authority safeguarding teams. Staff received regular training and updates. • The practice had reviewed and updated their safeguarding policies for children and vulnerable adults. The policies reflected the guidance within the intercollegiate documents relating to staff training in both safeguarding children and young people and safeguarding adults. We saw there was a specific page on the practice admin system which had all necessary resources and information including updates, specific areas like family support and modern slavery contact details and minutes of meetings. Regular monthly meetings were held, and minutes recorded. • Registers of vulnerable patients were regularly updated. Vulnerable children had a named GP and when they reached 18 years of age they were supported through the transition to adulthood and the different services out there for support. • Admin staff had responsibility to check alerts, twice a day, that came into the practice. Staff we spoke with told us that they had been trained to identify alerts and were given specific words to look out for that would identify a safeguarding concern. 	

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
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Explanation of any answers and additional evidence:

- The practice had an up-to-date recruitment policy and procedure that listed the processes to check applicants were suitable for their role. For example, the practice requested references, identity checks and undertook Disclosure and Barring Service (DBS) checks. Staff were interviewed and provided details of their employment history and qualifications for the practice to review.
- Newly recruited staff told us these processes had been followed and they found the interviews useful for asking questions and understanding the nature of the role.
- We reviewed three sets of staff files and these demonstrated that recruitment checks had been completed in line with regulations, including references and photographic ID. The practice used a checklist to ensure all checks and processes were signed off when they were done. Vaccination status was recorded on the admin system with reminders lags for dates for renewal of immunisations.

Safety systems and records	Y/N/Partial
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Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 14 December 2021	Yes
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There was a fire procedure.	Yes
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Date of fire risk assessment: Overton 21 April 2022 Oakley 21 April 2022 Kingsclere 24 November 2021	Yes
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Explanation of any answers and additional evidence:

At the previous inspection in January 2019 we found that not all actions had been completed following risk assessments and there were gaps in fire safety training.

At this inspection we saw evidence that all risk assessments were in place and actions completed. For example, a fire door at one of the sites had been repaired. Also, all staff had completed fire safety training and there were Fire Wardens identified for each site.

In addition, at the previous inspection in January 2019 we found that the practice's process to ensure actions from risk assessments were carried out was not consistent and did not give assurances that all risks to patient safety were mitigated. For example;

- We saw a Legionella risk assessment had been carried out for all sites however it had not been documented if actions required for ongoing monitoring had been conducted. We did not see evidence that water temperatures for the Overton or the Kingsclere branches were monitored. The practice was able to evidence that water temperatures were monitored at the Kingsclere branch but not for the Overton site in accordance with their risk assessment.

At this inspection we found that all risk assessments and actions resulting from, were completed.

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 Jan 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
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in 2019 we found that not all staff had completed an appropriate level of infection prevention and control (IPC) training.</p> <p>At this inspection we saw evidence that all staff had undertaken IPC training including handwashing and desk/equipment cleaning necessary during the COVID 19 pandemic. We saw a specific page on the practice intranet devoted to IPC and the COVID 19 pandemic. Quarterly meetings were held to inform and update staff on IPC issues.</p> <p>The most recent IPC audit has been completed in January 2022 and a number of actions had been identified. For example:</p> <ul style="list-style-type: none"> • Staff not sharing unwrapped food with other staff during events where staff previously would have shared food prior to the COVID 19 pandemic. Staff were advised to keep food in individual containers in the staff fridge. This was communicated to staff in the team leaders meeting. • The audit identified that not all pillows used in the practice were covered by a strong, intact, sealed plastic wipeable cover. This was noted as an action and the pillows had been replaced. 	

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:	

- Staff reported they felt there were enough staff and they could cover each other during busy periods. Staff also moved between sites to provide cover where required.
- A telephone system introduced in December 2019 and was a cloud-based system which allowed staff to access phones away from the practice across all three sites. The system allowed the practice to divert staff to work from home and take calls. Risk assessments were in place for staff working from home to ensure confidentiality.
- Receptionists were aware of how to call for assistance if they observed a patient who needed immediate medical help.
- Staff had received specific training on sepsis and stroke awareness. They knew the appropriate action to take and there were laminated sepsis guidance documents on display in treatment rooms and in reception, for staff to refer to.
- The practice had carried out a specific risk assessment after the Covid 19 pandemic to ensure that patients returning to the externally provided abdominal aortic aneurysm (AAA) clinic were safe. This included reviewing the patient journey for visiting the clinic and to ensure that external staff had sufficient equipment to keep them safe and that the consulting rooms used were compliant with the practice IPC practices.

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:

- At the last inspection in January 2019 we saw that the practice's system for summarising new patient notes was not fully embedded. The arrangement for staff to complete this task was not sustainable and was recognised by the practice who were trying to recruit to the post.
- During this inspection we found that the practice had introduced a new process with a dedicated member of staff. The new process included an action that if a patient had transferred and needed to be seen by a clinician before the notes had been received by the practice, the staff member would contact the previous practice and obtain a summary for the clinician to use.
- Our remote review of clinical records showed the records were completed in full and stored on a recognised electronic document management system.
- The practice had a specific member of staff responsible for coding patient records. They would check discharge summaries and add all information to the patient record and send a task to the pharmacy team to update any changes in medication and notify the GP, so they were aware.
- The GPs had a buddy system in place and all tasks were reviewed on a daily basis to ensure that no abnormal results were missed.

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)	0.67	0.70	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)	8.4%	10.5%	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)	5.00	5.69	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	75.6‰	113.9‰	129.2‰	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) <small>(NHSBSA)</small>	0.46	0.57	0.62	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) <small>(NHSBSA)</small>	6.5‰	9.1‰	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
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.	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.	Only at Kingsclere
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

Medicines management	Y/N/Partial
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> <p>At the previous inspection in January 2019 we found that the practice's system for securing and monitoring blank prescriptions was not in line with national guidance. However, immediately following the inspection, the practice sent confirmation that they had purchased locks for their printers and updated their prescription security protocol so that prescriptions were removed at the end of the day and put in room specific folders. However, they were still not logging serial numbers for blank prescriptions for specific rooms.</p> <p>During this inspection we found that the practice had introduced a new process and all prescription stationary was recorded and stored securely and in line with national guidance.</p> <p>At the previous inspection in January 2109 we found that the practice's arrangements to monitor stock levels of emergency medicines was not embedded at all sites. During this inspection we checked the levels of emergency medicines at all three sites and found appropriate stock levels were available.</p> <p>At the previous inspection in January 2109 we found that the practice's system for recording fridge temperatures for medicines requiring cold storage, was not embedded and we were not assured that the cold chain had maintained the safety and efficiency of medicines.</p> <p>During this inspection we reviewed the recording of fridge temperatures at all sites and were assured that these were carried out twice daily and recorded appropriately. There was a cold chain policy in place and staff we spoke with were able to explain the process.</p> <p>We saw Patient Group Directions (PGDs) followed national guidance and were appropriately signed by an authoriser. PGDs are written instructions to help supply or administer medicines to patients, usually in planned circumstances.</p> <p>During this inspection we undertook extensive remote (offsite) searches on the practice's clinical systems. These searches aligned to the findings of in-house medicine optimisation audits which identified that patient records were accurate and contained up to date recording of reviews of their medication. For example:</p> <ul style="list-style-type: none"> The clinical searches identified 91 patients who had been prescribed Methotrexate (a type of medicine called an immunosuppressant, used to control the body's immune response and help reduce inflammation) in the 12 months preceding the search. The clinical system showed that all the 91 patients (100%) had received the necessary monitoring. 	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Yes
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Yes
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Yes
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Yes
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Yes
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	N/A
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	N/A
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Yes
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes
<p>Explanation of any answers and other comments on dispensary services:</p> <ul style="list-style-type: none"> • Standard operating procedures were kept in the dispensary and on the practice shared drive. • Dispensing competencies were recorded every year and were recorded on the training system. • There was a system in place to check medicines expiry dates and those that were due to expire were removed and recorded. • The fridge in the dispensary had temperature checking log and a data logger to ensure the cold chain was maintained. 	

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:	3 significant events and 35 learning events
Number of events that required action:	3
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Any incidents which resulted in harm were recorded as significant events on the practice system. All other incidents were recorded as learning events. Staff we spoke with explained how they would report concerns or incident. Staff were able to discuss anything of concern and a Manager or Partner would then upload the incident onto the practice system. Trends and any issues were discussed in staff meetings and at monthly partners meeting as appropriate. All incidents and ongoing actions or learning was shared with all staff via the practice system and the twice a weekly 'huddle'. Complaints, compliments, learning events and significant events were summarised and shared with staff at meetings and recorded in the minutes. A meeting was held in January each year to discuss an annual summary of all events. 	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Delay in sending a two week wait referral	A checking system was put in place for two week wait referrals that were not seen within the correct timeframe. GPs used practice protocols when completing two week wait forms and this prompted a task to be sent to secretary as the final step in the process to ensure referrals would not be missed in future. A two week wait referral is a request from a GP to ask the hospital for an urgent appointment because the patient has symptoms that might indicate they have cancer.
Missed patient on duty face to face list	The appointment booking view on the computer system has been amended to show all different clinic sessions. Reception and other staff to check in with any patients who seem to have been waiting longer than expected.

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
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we saw the practice's system for receiving and acting on Medicines and Healthcare products Regulatory Agency (MHRA) alerts was not embedded. The practice did not have a consistent process for receiving and acting on MHRA alerts. The systems used had been brought forward before the merger between the practices had taken place. The process used by two of the sites did not ensure that actions required had been carried out adequately.</p> <p>During this inspection we found that the practice had a procedure which was consistently followed across all sites. We saw that the alerts were received via email, the clinical pharmacist actioned the alerts and carried out relevant patient searches. We saw there was a note added to the system which provided a timeframe by which to complete the relevant actions.</p>	

Effective

Rating: Good

QOF requirements were modified by NHS England 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

Effective care for the practice population

Findings
<ul style="list-style-type: none">• 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. The practice could refer to the Primary Care Network (PCN) Frailty/Proactive Care Nurse if appropriate.• 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 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 clinical team worked with district nurses and Frailty/Proactive Care nurses and home visits were carried out by the COPD (chronic obstructive pulmonary disease) nurse. The daily team meeting was used to discuss patient in this group.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. The practice had access to a mental health clinician through the Primary Care Network and could refer to this service.
- Patients with poor mental health, including dementia, were referred to appropriate services. If nurses had a concern, they told us they would arrange for the patient to book in with GP to be assessed.

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. Mandatory and long-term conditions specific training had been undertaken online during the COVID 19 pandemic, but face to face training was beginning to resume.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. The care coordinator monitored the discharge list informed the nurse to call the patient at home to provide support, including preventative measures. For example, ensuring medicine rescue packs and/or combined inhalers were in place and to remind patients to contact the practice sooner if they felt there was a concern or a trigger such as hay fever. Inhaler history for control and management plans were checked annually.
- The asthma care coordinator sent out questionnaires via text message and patients had an annual review arranged by birth month. If patients did not have access to a smart phone the practice would send a letter or call them to bring in the completed questionnaires.
- The practice identified clinically vulnerable patients who would be called for the nurses to check in with and offer support, for example, from the social prescriber and/or life coaches.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with asthma were offered an asthma management plan.
- Diabetes patients discussed regularly and in detail at regular meetings.

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)	134	146	91.8%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England)	149	149	100.0%	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)	146	149	98.0%	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)	147	149	98.7%	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)	174	180	96.7%	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 admin team were sent a task from the nurses to send out reminder messages after vaccination clinics, to the families of any children who were not brought in for immunisations.

Cancer Indicators	Practice	CCG average	England average	England comparison
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The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/09/2021) (Public Health England)	80.3%	N/A	80% Target	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	71.6%	62.8%	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)	77.9%	70.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (PHE)	59.0%	53.3%	55.4%	No statistical variation

Unverified data provided by the practice showed that they had increased the achievement for cervical screening to 83%.

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
Explanation of any answers and additional evidence:	
GPs and nurses were sent notifications of patients discharged and these were reviewed by the most appropriate clinician.	

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

- The practice carried out a rolling audit of the treatment and reviews of diabetic patients across all three sites. They put in place a multidisciplinary team to review patients on all eight care processes to give the best clinical outcome for patients. Patients were reviewed every three months to ensure their condition was correctly managed. The process had been adopted by the local clinical

commissioning group and had already begun to show improvements in targets across the local area. The practice also shared with us the work they had done though the Covid 19 pandemic to ensure patients had appropriate access to appointments and clinical care. Between March 2021 and March 2022, with a list size of approximately, 18,686, the practice carried out 14,043 face to face appointments with a clinician, 49,989 telephone appointments and 869 home visits.

Any additional evidence or comments

Staff had added a Learning Disabilities topic page to the practice intranet, which was regularly updated by the GP Lead and admin team. There were also regular updates for all clinicians to make them aware of new resources and what should be considered when they carried out an annual review for patients in this group.

The practice worked regularly with the local Primary Care Network and met regularly to review quality improvement targets for areas including End of Life pathways and prescribing data.

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.	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:

At the previous inspection the practice was unable to give assurances that all staff had received training appropriate to their role and in line with practice policy. For example, the practice log of staff training did not evidence that all staff had received information governance, fire safety and safeguarding training.

At this inspection we found that the practice had a comprehensive training record in place with notifications when training needed to be updated. We saw evidence that all staff had completed mandatory training. In addition;

- Staff were given allotted time to complete training.
- Staff told us that the practice management were supportive to training requests.
- Appraisals were completed annually by the appropriate manager. Each new member of staff had a review in the four to six weeks of commencing employment.

- Clinical competencies were checked by an appropriate clinician. Observed practice for clinicians had been re-introduced. The nurse manager sampled and reviewed nurse notes prior to carrying out appraisals.
- Staff we spoke with told us that the practice encouraged and supported internal promotion.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Meetings were held with community services daily and notes were stored on the practice system for all clinical staff to access. • Treatment and care were provided in line with guidance, often using templates which prompted the recording of consent. • We reviewed a selection records where do not attempt cardiopulmonary resuscitation (DNACPR) decisions had been discussed. These showed patients views were considered and care decisions were recorded in detail. 	

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"> • Staff signposted patients for stop smoking advice and access to the life coach from the Primary Care Network. • Pre-diabetic and newly diagnosed patients were referred to specific courses to provide information, guidance and support. 	

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"> • Our review of records shows an assessment of patients' mental capacity was recorded appropriately and in line with legal guidance. 	

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 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Throughout the Covid 19 pandemic the practice always remained open and accessible for patients. • The practice closely monitored the numbers of patients requiring an on the day appointment to ensure there were sufficient clinicians to manage the demand. • The duty team spoke with every patient on the triage list on the day. Patients were triaged by a member of the duty team first and then a decision to allocate an appointment was made. In all cases if a patient needed a face to face appointment or home visits would be organised. • A range of appointments were available including, direct booking by the NHS 111 service, daily duty list, rapid access and/or routine face to face appointments. Other appointments could be offered, for example, nurses, health care assistants, and blood tests. Improved access appointments were offered between 6.30pm and 8pm Monday, Tuesday, Fridays and on Saturdays between 9am and 11am. • The practice offered appointments by telephone and video and could access interpretation services if required. • The practice telephone message, website and social media pages were regularly updated, to ensure patients were aware of any changes. For example, opening times and training sessions. The practice also placed updates in local publications. 	

Well-led

Rating: Good

At the previous in section in January 2019 the practice was rated as Requires Improvement for Well-Led. We found the practice did not have proper oversight of staff training and could not be assured that all staff had received training appropriate to their role.

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"> The practice had a workforce plan in place which included a matrix to demonstrate the future staffing needs, taking into account staff turnover, retirements and increase in patient population and need. This was reviewed every 6 months. GPs and practice management roles had a progression plan in place for the assistant practice management team to cover all roles to make the practice sustainable. Staff we spoke with told us that managers were approachable and easy to talk to. A range of staff meetings were held regularly, and they held a 'huddle' takes place every Tuesday and Thursday morning.. Minutes of these meetings were available to staff who were not able to attend. 	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practices vision and values and strategic objectives were developed with the whole team in 2019 at the time of the merger. There was a business plan in place, and we saw that the objectives overlaid the plan. This was monitored through an away day for partners and practice management team, held in January, each year. Staff told us that they had been involved with the process and were encouraged to bring previous experience and share ideas. Local veterans had attended a previous event with the practice and 	

the Primary Care Network (PCN) to give their view on what works well what is a challenge for them as patients and individuals.

- There was a GP partner attached to the PCN who attended meetings and relayed relevant information to staff.

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"> • Staff we spoke with told us that the GPs and management team were supportive. • Meetings were held regularly and gave an opportunity to review and discuss significant events and alerts. In addition, staff explained that the twice weekly 'huddles' were a good point to keep all staff informed of changes. • The management team had put in place an employee assistance programme to give staff access to external service, for example, counselling and occupational help support. • The practice had its own Freedom to Speak Up Guardian and had a reciprocal arrangement with another PCN practice to give autonomy. 	

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

Source	Feedback
Staff	<p>All staff we spoke said they liked working at the practice. They commented that:</p> <ul style="list-style-type: none"> • The practice was a friendly workplace. • Leaders were friendly and the practice was a warm and positive environment to work in. • They felt listened to and the management team were very forward thinking, proactive and adaptable to change. • It was a very dedicated team and the changes through the COVID 19 pandemic had been unprecedented and they felt they had adapted well to the changes and challenges.

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:	
At the time of the previous inspection the practice had recently completed the merger and did not have all policies, process and procedures in place across all three sites.	
During this inspection we saw evidence that all documentation had rolled out over the three sites and staff were aware of how to access them and there was a schedule for review in place.	

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.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place. Team net, and hard copy.	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:	
At the previous inspection we found that the practice did not always carry out actions as identified in their risk assessments. Also, the practice's process for ensuring compliance with a fire risk assessment did not give appropriate assurances. For example, on the fire risk assessments conducted, no actions had been recorded as completed.	
During this inspection we found that action had been taken in response to findings and the practice had made improvements and embedded them in the practice. Similarly, there were effective processes to respond to other external reports and any recommendations to reduce risks.	
In addition	

- Staff used smart cards to access this system and passwords were changed regularly and when requested by the Clinical Commissioning Group (CCG). Management staff monitored compliance through observation.
- The practice's confidential waste policy outlined the requirements for keeping all personally identifiable information safe. The practice had a contract with an external waste contractor for the removal and destruction of confidential waste.
- The practice used a workforce planning tool to look at forecasting practice needs, and numbers of staff required to address increases in practice list.

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"> • The practice followed revised standard operating procedures during the COVID-19 pandemic and updated policies to support patients and staff. • At the early stages of the pandemic, practice staff contacted patients identified as vulnerable and those at risk to check they had the support they needed. • Systems were in place to enable patients to see a GP throughout the pandemic if this was clinically indicated. • The dispensary adjusted their ways of working, and new windows were installed in the dispensary to ensure safety for patients and staff. • The practice had risk assessed each room to assess number of people in each room to support social distancing. This was displayed on the door of each room. • The practice website and telephone answering message were kept updated with relevant information, for example about appointments and vaccinations. • The practice intranet had a specific page to cover all aspects of the Covid 19 pandemic, to keep staff aware of the ongoing changes. 	

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
<p>At the previous inspection the practice could not demonstrate proper oversight of staff training. Not all staff training records had been combined and were kept across different databases.</p> <p>During this inspection we reviewed the training matrix and all staff had completed training in areas appropriate to their roles. Staff we spoke with told us that they were given time away from their job role to complete training.</p> <ul style="list-style-type: none"> • The practice used a range of data including daily activity and demand report, workforce returns, and a workforce diagnostic tool, to review performance. • They used the clinical system searches to review numbers of GPs versus number of appointments required. • All clinicians had an annual appraisal and five yearly appraisals. As part of these processes, performance, including significant events and continuing professional development was discussed and reviewed. • All other staff had annual appraisals. During these meetings all aspects of performance, feedback and attendance were reviewed. Good performance was celebrated, and any learning shared. If required action plans were put in place to improve performance outcomes along specified and recorded aims and timescales. • If required ad hoc performance reviews were carried out with staff members to raise any concerns, we were told that the managers would listen to the individual's response and put in place an action plan to mitigate and improve the situation. • We saw evidence that performance issues were dealt with in a transparent and supportive manner with the aim of maintaining a high standard of care, whilst enabling the member of staff to make the appropriate adjustments to improve performance • The registered manager notified CQC appropriately of any changes and events, in line with statutory requirements. 	

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Staff were reminded about information security and all staff were up to date with mandatory information management training. The website included information about the management of patient information, how it was stored and the practice document retention policy. It also summarised patient rights for sharing information. 	

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 (PPG).	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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice had worked continually with the PPG to engage them in the ongoing strategy 	

Feedback

<ul style="list-style-type: none"> We spoke with the PPG and were told that this was a patient-focused practice, where all staff put the patient first and the staff worked well together as team. They reported the practice worked effectively during the pandemic and clinicians provided appropriate services to their patients in a timely way and carried out face to face appointments and home visits when this was needed or requested.

- There was a culture of kindness and consideration, where all staff cared about the patient population.

Any additional evidence

The Friends and Family survey from March to April 2022 showed 97% of 348 patients who completed the survey said that they would recommend the practice to their friends and family.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The partners held an away day in October 2021 to assess the effects that the Covid 19 pandemic had had on the practice and how they planned to move forward to implement change and acknowledge the hard work that all the staff had put in through a very challenging time. There had also been events in January 2022 with more planned later in the year. • Staff we spoke with said that the practice always supported training requests. • The practice had a member of staff who had enrolled on the Nurse Associate apprenticeship, and other staff including non-clinical members who had started other apprenticeship programmes. 	

Examples of continuous learning and improvement

We were given evidence of a range of training courses that staff had been through including for example;

- A Paramedic through Advanced Clinical Practitioner programme
- The whole reception team and the practice managers on the Training on the Community Pharmacy Referral Scheme.

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.
-
- ‰ = per thousand.