

Inspection Evidence Table

Woodland Drive Medical Centre

(1-2026733177)

Inspection Date: 26, 27 and 28 September 2023

Date of data download: 11/10/2023

Overall rating: Good

Context

We inspected this practice on 26 May 2021 to follow up on concerns we received about the practice. This was undertaken using a pilot methodology for a remote GP focused inspection and therefore we could not rate or amend ratings for the practice at this time. We found a breach of regulations in that systems and processes to ensure good governance in accordance with the fundamental standards of care were not effectively managed.

We inspected the practice in May 2022 to follow up the breach identified at the 2021 inspection, and we rated the practice requires improvement overall and for providing safe, effective and well-led services, we reviewed access but did not rate the responsive key question and they remained as good. We found that some improvements had been made since the 2021 inspection. Patient care and treatment had mostly been well managed and maintained during the pandemic and the practice had provided support to their vulnerable patients. Access to appointments had been maintained and improved. However, we found breaches of regulations in that recruitment procedures were not established and operated ineffectively and systems and processes to ensure good governance in accordance with the fundamental standards of care were not effectively managed and staff had not completed appropriate training.

We inspected the practice in September 2023 to follow-up the breaches identified at the 2022 inspection and found improvement in the overall governance arrangements including:

- Systems, practices, and processes to keep people safe and safeguarded from abuse.
- Systems to assess, monitor and manage risks to patient safety.
- Systems for the appropriate and safe use of medicines, including medicines optimisation.
- Systems to monitor care and treatment of patients with long term conditions.
- Provision and monitoring of staff training.
- Incident reporting systems.

We also saw the provider had continued to improve and provide good access to the service and patient survey data was positive.

We have rated the service good overall and for providing effective, responsive and well-led services. We have rated the service as requires improvement for providing safe services because:

- Disclosure and Barring service checks had not always been obtained prior to employment of staff and a risk assessment had not been completed to support this decision.
- Fire drills had not been completed.
- Emergency equipment had not been checked at the recommended intervals.

Safe

Rating: Requires improvement

At the inspection in May 2022, we rated the service requires improvement for providing safe services because:

- The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.
- There were gaps in systems to assess, monitor and manage risks to patient safety.
- The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation.
- The practice learned and made improvements when things went wrong but incident reporting systems were not effective.

At the inspection in September 2023, we found improvements had been made and most areas above had been addressed. However, we rated the service as requires improvement for providing safe services because:

- Disclosure and Barring service checks had not always been obtained prior to employment of staff and a risk assessment had not been completed to support this decision.
- Fire drills had not been completed.
- Emergency equipment had not been checked at the recommended intervals.
- Minimum and maximum temperatures had not been recorded to enable identification of any possible cold chain breach in the vaccine storage refrigerator. The practice policy and procedure had not been updated to include the process for use of the vaccine refrigerator temperature data loggers and action to take in the event of a break in cold chain had not been reviewed following an incident.

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse but some had not been fully implemented.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y

There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	P (1)
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in May 2022, we found most staff had not completed the relevant level of safeguarding training for their role and training was not monitored by the provider. Disclosure and Barring Service (DBS) checks were not carried out for all staff and this decision was not supported by a risk assessment.</p> <p>At our inspection in September 2023, we found some improvements:</p> <ul style="list-style-type: none"> • Staff had completed the relevant level of safeguarding training and completion was monitored by the practice manager. • (1) We reviewed 3 staff recruitment records. We found all had the relevant DBS checks in place, but these had not always been obtained prior to employment. For example, a DBS for a clinical member of staff had not been obtained until 5 months after the start date. A risk assessment to support starting the member of staff before receipt of a DBS had not been completed. A risk assessment process had been developed and had been appropriately completed for 1 non-clinical member of staff who had not had a DBS check completed. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	P(1)
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in May 2022, we found the practice recruitment policy had not been fully implemented in respect of references as no references were obtained for locum clinical staff and references had been obtained some weeks after employment for other staff. Staff full vaccination status had not been obtained where relevant to their role.</p> <p>At the September 2023 inspection we found some improvements had been made:</p> <ul style="list-style-type: none"> • New procedures had been developed to support the recruitment of locums and to ensure all the required information was obtained. We looked at 3 staff recruitment files and all had references in place. • (1) DBS checks had not always been obtained prior to recruitment. • We also observed the practice had accessed occupational health support for health assessment during the recruitment process and information about staff vaccination was held on file. Only partial vaccination records had been provided for 1 locum clinical member of staff. The practice manager was aware of this and was addressing it with the employment agency. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: 17 February 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: 24 April 2023	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the May 2022 inspection we found action had not been taken to address findings from a Legionella risk assessment. The fire risk assessment and action plan were not up to date, fire safety checks were not completed, and staff fire training had not been undertaken.</p> <p>At the September 2023 inspection we found improvements had been made:</p> <ul style="list-style-type: none"> Records showed action had been taken in respect of the Legionella risk assessment and appropriate regular checks were being completed. A fire risk assessment had been completed by an external company and fire alarm and emergency lighting checks had been completed. Fire training had been completed by all staff. However, fire drills had not been completed and this issue had not been identified in the fire risk assessment. The manager told us she would undertake fire drills with the staff. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: 16 December 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in May 2022, we found the practice was exceptionally clean and tidy, however, not all staff had completed infection prevention and control (IPC) training, sharps bins had not been changed within recommended timescales and some single use equipment had exceeded its expiry date.</p>	

At the inspection in September 2023, we found the practice remained exceptionally clean and tidy, and they had scored 98% in their last audit completed by the local IPC team. We observed improvements had been made:

- Staff had completed IPC training.
- Sharps bins had been changed within recommended timescales.
- There were systems in place to ensure single use equipment did not exceed its expiry date.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in May 2022, we found not all the recommended emergency equipment such as medical oxygen and emergency medicines were available, and a risk assessment had not been completed to support non-provision.</p> <p>At the September 2023 inspection we found improvements had been made:</p> <ul style="list-style-type: none"> • Most recommended emergency medicines and equipment had been provided and any non-provision was supported by a risk assessment. • Emergency medicines and equipment were regularly checked but not at the recommended frequency. The practice manager told us they would review this. 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y

There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a clear system and timely management of laboratory results and tasks such as referrals. Systems were also in place to ensure patients would be contacted and reminded when they required a future follow up appointment. • Records of patients urgently referred to secondary care were maintained through the 'C the signs' reporting system. This enabled all involved with the patients care and treatment to monitor the journey through referral and treatment. We observed good management of the system and monitoring to ensure patients were seen. 	

Appropriate and safe use of medicines

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

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.94	1.02	0.91	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). (01/07/2022 to 30/06/2023) (NHSBSA)	4.5%	5.3%	7.8%	Tending towards variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2023 to 30/06/2023) (NHSBSA)	6.29	5.07	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	156.6‰	252.9‰	129.5‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.48	0.81	0.54	No statistical variation

Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	5.9‰	6.1‰	6.8‰	No statistical variation
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Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	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.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	P (1)
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	P (2)
Explanation of any answers and additional evidence, including from clinical searches.	
At the inspection in May 2022, we found not all the recommended emergency equipment and emergency medicines were available, a risk assessment had not been completed to support non provision and these medicines were not stored appropriately. The policy for the management of blank prescriptions had not been fully	

implemented and records of distribution did not provide a complete audit trail. Patient group directions were not appropriately authorised. Monitoring patients' health in relation to the use of medicines had not always been adequately completed.

At the inspection in September 2023, we found improvements had been made:

- (1) Most recommended emergency medicines and equipment had been provided and any non-provision was supported by a risk assessment. Emergency medicines and equipment were regularly checked but not at the recommended frequency as per the Resuscitation Council UK's guidance. The practice manager told us they would review this.
- Management of blank prescriptions had improved, and records of distribution now provided a complete audit trail.
- Patient group directions were now appropriately authorised.
- Monitoring patients' health in relation to the use of medicines had improved:
 All 19 patients prescribed a medicine for inflammatory conditions such as rheumatoid arthritis, had had the required monitoring checks completed. We noted 2 patients required an alert entering on their records that they were prescribed this medicine and the day of week to take the medicine recorded on their prescription. The provider had completed an audit and had identified this and told us they would further review this.
 Records showed patients with asthma who required 2 or more courses of rescue steroids were well managed and regularly reviewed. We noted 1 patient required a steroid card.
 144 patients were prescribed an anticoagulant, 7 of these had not had the required monitoring. We looked at 5 of these patients records and found 4 had not had creatine clearance calculated to check kidney function and 2 of these patients had not had their weight taken or blood tests. The provider told us they were aware of this and had a process in place to improve this.
 27 patients were prescribed a medicine for depression, and all had been reviewed and given appropriate advice.
- (2) Checks on the temperatures of the vaccine storage fridges were completed and showed the current temperature. Minimum and maximum temperatures had not been recorded to enable identification of any possible cold chain breach. Data loggers had been provided since the last inspection to assist in monitoring the temperatures and identify any cold chain breaches. We observed the practice policy and procedure had not been updated to include the process for use of the data loggers and action to take in the event of a break in cold chain had not been reviewed following an incident.

Track record on safety and lessons learned and improvements made
The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y

There was evidence of learning and dissemination of information.	P (1)
Number of events recorded in last 12 months:	10
Number of events that required action:	10
<p>Explanation of any answers and additional evidence:</p> <p>At the May 2022 inspection we found a lack of effective recording and implementation of the incident policy and procedure.</p> <p>At the September 2023 inspection we found improvements had been made:</p> <ul style="list-style-type: none"> Incidents were generally well recorded, and action had been taken in response and learning had been shared. We observed duty of candour was implemented when required and incidents were discussed in meetings. <p>(1) However, one incident in the summer of 2022 which resulted in a short temporary closure of the practice and a breach of the cold chain for storage of vaccines had not been adequately recorded and records lacked detail about the date of the incident and actions taken. Staff were able to describe the action taken in response to the incident to ensure patient safety but there had been no reflection or learning identified. We identified that there was learning in relation to the policy and procedures relating to the practice contingency plan and management of vaccines however, these had not been reviewed and updated since the incident.</p>	

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

Event	Specific action taken
Safeguarding incident.	Staff had been vigilant in identifying the issues and social services had been contacted. The incident had been discussed in a staff meeting.
Scanning error.	External agencies were contacted for advice. Duty of candour policies were implemented and the patient was contacted.
Local fire causing power cut and smoke to enter the building.	Building temporarily closed. Patients informed. Vaccines isolated and destroyed due to cold chain breach.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the May 2022 inspection we found a small number of cases where safety alerts appeared not to have been actioned appropriately.</p> <p>At the inspection in September 2023, we found improvements had been made and our searches identified only one patient who had not been informed of the risks of their medicine and the provider told us they would address this.</p>	

Effective

Rating: Good

At the inspection in May 2022, we rated the service as requires improvement for providing effective services because:

- The practice had not effectively monitored care and treatment of some patients with long term conditions.
- The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

At the September 2023 inspection we found improvements had been made in the above areas and we rated the service as good for providing effective services.

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

Patients' needs were assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	

- Regular clinical meetings and multi-disciplinary team meetings were held to share information.
- Access to care and treatment was well managed and consultations and reviews could be completed by telephone or in face-to-face appointments.
- Dedicated staff, such as the social prescriber, contacted vulnerable patients to check for any social needs and to offer support. They also sourced and shared information with patients such as information about food banks and community schemes.

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances. The practice used a system, 'recovery steps', provided by the Local Authority. The practice could refer into this scheme or patients could self-refer.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice had lead members of staff for dementia, mental health, asthma and chronic obstructive pulmonary disease. They supported the practice by monitoring and booking patients' review appointments.

Management of people with long term conditions

Findings

- At the inspection in May 2022, we found improvements in the care of patients with long term conditions but patients with asthma and those with a thyroid condition had not always had the recommended monitoring.
- At the inspection in September 2023, we found improvements had continued to be made and patients with long term conditions had been well managed and received the recommended reviews and monitoring. We found 2 patients with a thyroid problem who had not had the recommended monitoring, but records showed the practice had attempted to engage with them. The practice manager told us during the inspection that both patients had been contacted again and appointments were scheduled.

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 influenzae type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	37	40	92.5%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	48	49	98.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	48	49	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	48	49	98.0%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	43	44	97.7%	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
<p>The practice had maintained high levels of uptake with the childhood immunisation programme since at least 2017 and they had managed to also maintain this during the pandemic.</p> <p>The practice manager closely monitored uptake and batch messaging was sent to parents/guardians to invite them to attend. They offered set baby clinic times and appointments at different times to meet patients' needs and they offered opportunistic immunisations. One of the administration staff had a lead role in this area. They contacted the patient's parent/guardian to book the clinics and to remind them before appointments. Parents/guardians could also be offered an appointment to discuss any concerns they may have about the immunisation programme.</p>

Cancer Indicators	Practice	SICBL average	England	England comparison
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Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	68.5%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	74%	N/A	70.3%	N/A
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). (3/31/2023 to 3/31/2023) (UKHSA)	78.9%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	32.0%	44.3%	54.9%	Tending towards variation (negative)

Any additional evidence or comments

- The practice had improved uptake for cervical cancer screening since 2017 (75% uptake) and prior to the pandemic had exceeded the 80% target. The practice had one practice nurse who completed cervical screening with another nurse in training. A member of the administration team had the lead role in this area for monitoring uptake and contacting patients to arrange screening. Cervical screening was also offered opportunistically as appropriate.
- The practice had a care coordinator who reviewed primary care provision for cancer care and signposted patients to Macmillan services and for benefits checks.
- We discussed the low cancer cases detection rate data and the provider told us they thought this may be due to over referral but that they would review this.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
<p>Three single cycle clinical audits were provided which had been undertaken in the past 12 months:</p> <ul style="list-style-type: none"> • An audit to check the prescribing and review of a medicine that requires monitoring had been completed. This showed that all but one patient had received the recommended review but that this patient had been contacted. The results from our clinical searches showed that the recommended monitoring schedule had been maintained. 	

- An audit of patients prescribed an oral nutritional supplement had been completed and an action plan had been developed where this showed that patients may no longer meet the criteria for this.
- An audit of antibiotic prescribing had been completed. This showed that 100% of the use of antibiotics was justified but only 50% met the guidance for choice of antibiotic prescribed. An action had been developed and this included sharing information with prescribers.

We also noted at this inspection that improvement plans from audit activity provided at the last inspection had led to improvement in prescribing where a safety alert had been issued.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in May 2022, we found staff had not completed the required training for at least 2 years.</p> <p>At the inspection in September 2023, we found improvements had been made:</p> <ul style="list-style-type: none"> • Staff training was up to date and staff had the opportunity to complete further training for their role. The practice manager was monitoring completion of training. • Appraisals had been maintained and were completed annually, and 360-degree feedback had been implemented to provide a wider picture of performance. 	

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: The practice hosted a social prescriber and health and wellbeing coordinator who helped to signpost patients to community services. They also hosted a first contact physiotherapist and pharmacist. A mental health practitioner was available to support the practice via the local primary care network (PCN).	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence.</p> <p>We reviewed 3 patients records where DNACPR decisions had been made. Only one had been completed by the practice and the records of the decision-making process were detailed and a copy of the form was stored on the patient's record. The other 2 decisions had been made in secondary care. One did not have a copy of the DNACPR form on the patient's record, but it was indicated that the patient had a copy of the form at home. Contact was made with the patient to request a copy.</p>	

Responsive

Rating: Good

We have rated the service as good for providing responsive services because:

- The practice organised and delivered services to meet patients' needs.
- People were able to access care and treatment in a timely way.
- Complaints were listened and responded to and used to improve the quality of care.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider was proactive in meeting patients' needs. Patients' needs were recorded, and an alert was placed on their records if specific assistance was required. For example, if patients had anxiety a quiet room could be provided while the patient waited, or they could enter via another door and go straight into the consulting room. Where children had difficulties accessing the practice due to learning difficulties, they communicated with the parents to discuss their needs to ensure a positive experience.</p> <p>The practice had adjusted its extended hours times from evenings to early mornings in response to feedback and number of patients who did not attend in the evenings.</p>	

The practice had 1 care home aligned to the practice and a weekly multidisciplinary team meeting was held to discuss patient's needs. The practice provided the care home with a direct dial telephone number to aid effective communication.

The practice recorded patient's communication needs, and any support patients required. The staff had access to translation services and the electronic check-in system was available in several languages. The practice provided letters in a patient's first language. Easy read material and a hearing loop was available.

Home visit requests were triaged by a clinician and the local GP federation provided additional home visit requests for acute problems.

Practice Opening Times

Day	Time
Telephone Opening times:	Monday to Friday 8am – 6pm 6pm - 6.30pm the practice phone lines were covered by the local GP Federation.
Appointments available:	
Monday	6.30am – 10.30am and 14.10pm – 16.40pm
Tuesday	6.30am – 10.30am and 14.10pm – 16.40pm
Wednesday	10am – 12.30pm and 2pm -16.30pm
Thursday	9am - 12pm and 2pm -5pm
Friday	10am – 12.30pm and 2pm -16.30pm
<p>Extended hours were provided by i-HEART Barnsley 365 and they provided appointments during the evening and weekends. The phone lines were open from 4pm – 6pm on Monday to Friday and from 8am – 9.30am on Saturday, Sunday, and Bank Holidays. Appointments were available at 3 other local GP practices.</p> <p>Out of hours services were provided via NHS 111.</p>	<p>Monday to Friday, 6.30pm – 10.30pm</p> <p>Saturday 9am - 5pm</p> <p>Sunday and Bank Holidays 10am – 2pm</p>

Further information about how the practice is responding to the needs of their population

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child under 2 years were offered a same day appointment when necessary.
- The practice was open from 6.30am on a Monday and Tuesday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- People in vulnerable circumstances were able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- The practice was proactive and flexible in meeting the needs of parents/guardians and had a history of high rates of immunisation uptake.
- The practice recorded individuals' needs to ensure they could support patients to access the practice.
- The practice used translation services and provided letters in a patient's first language.

Access to the service

People were able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • At the inspection in May 2022 the practice told us they had invested in a new telephone system in response to complaints from patients. The new system enabled management to monitor incoming calls, abandoned calls and call waiting times. The system also recorded all conversations and where necessary could be managed remotely. They told us they had further improved the telephone system since the May 2022 inspection to offer patients a call back rather than waiting in a queue and a feature enabling patients to 	

leave a message to cancel an appointment. Data from the National GP Patient Survey showed the practice continued to perform above national and/or local averages and had continued to improve. For example, 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 had improved from 64.52% in April 2022 to 77.6% in 2023 and the percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment had improved from 50.91% in April 2022 to 67.3% in 2023.

- Satisfaction with appointment times had decreased between 2021 and 2022 but remained static between 2022 and 2023. The practice had adjusted its extended hours times from evenings to early mornings in response to feedback and the number of patients who did not attend their appointments in the evenings. Following a trial period offering this 1 morning per week it was extended to 2 mornings due to the positive patient feedback. Appointments were available to be booked up to 2 weeks in advance.
- The practice had put systems in place to support patients during the pandemic such as telephone and video consultations. The practice had continued to offer telephone/video consultations, but patients were given a choice if they wanted to come in for a face-to-face consultation or have a telephone consultation.

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
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 (01/01/2023 to 30/04/2023)	77.6%	N/A	49.6%	Significant variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	67.3%	48.0%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	51.0%	49.5%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	75.6%	73.4%	72.0%	No statistical variation

Source	Feedback
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NHS.uk website (formerly NHS Choices)	2 positive reviews recorded about access in 2022.
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Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	5
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	5
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Example(s) of learning from complaints.

Complaint	Specific action taken
Attitude of GP	Investigation completed and letter of apology sent to the patient.

Well-led

Rating: Good

At the May 2022 inspection we rated this service as requires improvement for providing well-led services because:

- The practice culture did not always effectively support high quality sustainable care.
- The overall governance arrangements were ineffective.
- The practice did not have clear and effective processes for managing risks, issues and performance.
- There was limited evidence of systems and processes for learning, continuous improvement and innovation.

At the inspection in September 2023, we have rated the service as good for providing well-led services because improvements had been made in all the above areas.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice was fully engaged with the local primary care network.</p> <p>Succession planning was in the very early stages but was being considered. The provider had recruited a salaried GP since the last inspection.</p>	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a 5 year business plan in place with long and short-term goals identified and this was in the process of being updated. The practice vision, values and principles were clearly defined and included putting the patient at the heart of what they do, with decisions driven by improving health and wellbeing of patients. Observations during the inspection showed the team, led by the provider and the practice manager, were passionate about providing patient centred care.</p>	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the May 2022 inspection we found fire safety and Legionella risks were not well managed within the practice. Contact details of the Freedom to Speak up Guardian was not included in the policy and procedure, and staff had not completed equality and diversity training.</p> <p>At the inspection in September 2023, we found improvements had been made:</p> <ul style="list-style-type: none"> • Fire safety and Legionella risk management had improved, and records were maintained. • The Freedom to Speak up Guardian contact details had been included in the policy and procedure. • Staff had completed equality and diversity training. <p>We also saw evidence that the duty of candour policy and procedure had been implemented as required.</p>	

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

Source	Feedback
Staff	Staff told us they felt well supported and listened to. They said they were involved in meetings and had completed their training. They told us patients came first and they were happy working in the practice.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y

Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in May 2022, we found some policies and procedures had not been fully implemented such as for recruitment and incident reporting. We also identified some risk assessment processes which were not fully embedded such as for fire safety and management of legionella. There was a lack of management oversight of staff training. We also observed the practice last CQC rating was not displayed on the practice website. The practice manager provided evidence they had contacted the web designer immediately to address this matter.</p> <p>At the inspection in September 2023, we found improvements had been made:</p> <ul style="list-style-type: none"> • There was some improvement in recruitment although DBS processes had not been fully implemented. • There was improvement in the management of risk. • Staff were now up to date with their training, and this was monitored. • The web site had been updated and improved and included the CQC rating. 	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the May 2022 inspection we found systems for fire safety, staff recruitment and legionella, were not fully implemented or embedded. There was also a lack of management oversight of staff training and staff training in most areas was not up to date. Emergency medicines provision had not been risk assessed and not all recommended items were provided.</p> <p>At the inspection in September 2023, we found improvements had been made in all areas identified at the last inspection and there was improved management oversight.</p>	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was management oversight of internal and external data such as patient surveys and this information was used to improve services such as access by telephone. The new telephone system enabled management to monitor calls into the practice including call volume, time to answer calls and abandoned calls. This had enabled the practice to improve levels of patient satisfaction with access. 	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had several policies and procedures to support data protection including working from home which required signed authorisation. A data protection risk assessment had been completed. Information on data protection was displayed for patients. All areas were extremely tidy and well organised, and the clear desk policy was adhered to. All staff had received General Data Protection Regulation (GDPR) training. 	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had developed a virtual patient group they had called the patient reference group. They had involved the patient group in a recent survey about the service and were completing an action plan in response to the findings. They reviewed the friends and family test results and we observed these were all positive. • They told us they monitored the National GP survey for feedback and online reviews and social media. They also stated they took note of patient feedback from the GPs 360-degree feedback completed as part of their appraisals and any concerns or complaints. Data available to CQC showed patient satisfaction was in line with local and national averages. • Feedback was gathered from staff at the regular meetings and staff told us they were able to provide feedback and felt listened to. • We noted that any patient comments were collected by all staff and fed back to the manager and this feedback was recorded. • There was evidence the provider had implemented new systems in response to patient feedback such as a new telephone system and appointment times. 	

Continuous improvement and innovation

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

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

Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the May 2022 inspection we found there was a system for staff learning and development but there was little oversight of this to ensure staff completed the required training. Incidents were recorded and learning from incidents was shared but some opportunities for learning were missed. The practice had taken immediate action to address most of our findings from the inspection and were motivated to improve.</p> <p>At the September 2023, inspection we found:</p> <ul style="list-style-type: none"> Action had been taken in response to our last inspection and most of the areas identified had been improved. There had been significant improvements to staff training and staff had accessed additional training for their role. Recording of incidents had improved and we saw evidence of learning and that learning had been shared with staff. However, 1 incident required further review as learning opportunities had not been identified. Action had been taken in response to clinical audits and improvements had been made to care and treatment in relation to medicines that required monitoring. Action had been taken in response to patient feedback to improve access. 	

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 practices 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 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 those aged 25 to 49, and within 5.5 years for those aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

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