

Care Quality Commission

Inspection Evidence Table

Whitecliff Surgery (1-583438097)

Inspection date: 26 October 2022

Date of data download: 28 October 2022

Overall rating: Requires Improvement

At the last inspection in July 2016, the practice was rated Good overall. At this inspection we found some issues in Safe and Well-led domains, which resulted in breach of regulation 17 (HSCA) Good governance and we rated the service as Requires Improvement overall.

Safe

Rating: Requires Improvement

At the last inspection in July 2016, we rated the practice as Good for providing safe services. At this inspection we rated this key question as Requires Improvement, we found a lack of oversight in areas that have led to a breach of regulation 17 (HSCA) Good governance:

- There were gaps in safeguarding training with clinicians not being trained to the appropriate levels that were essential to their roles.
- There were shortfalls in the completion of records of staff vaccination for all clinical staff.
- Actions from health and safety and Infection Prevention Control (IPC) audits had not been completed.
- There were gaps in the process to ensure safe and appropriate authorisation for Patient Group Directions (PGD) and/or Patient Specific Directions (PSD).
- The practice was not able to demonstrate the prescribing competence of non-medical prescribers.

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.	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes

Safeguarding	Y/N/Partial
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: At the time of the inspection, we found that not all staff were trained to appropriate levels for their role in safeguarding. For example, we found that one GP partner had not had their training in safeguarding for children and adults since July 2016. There were three nurses in the practice who had out of date training for child safeguarding level three and two who had not had adult safeguarding level three. All clinical staff should be trained to level three in safeguarding, including GPs, practice nurses and paramedics in line with intercollegiate guidance. After the inspection, the provider sent us evidence of updated records showing all relevant staff had completed appropriate safeguarding training.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial
<p>Explanation of any answers and additional evidence: Not all staff vaccination records were maintained in line with the current guidance at the time of the inspection. For example, the provider collected information from Health Care Assistants (HCA) about their vaccination status prior to employment. Pre-employment vaccination status was not obtained for other clinical staff, including GPs and nurses. After the inspection, the provider submitted a vaccination disclaimer form which was incorporated into their practice. Moving forward, each clinician was asked to declare their vaccination status to ensure this was maintained in line with current guidelines.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 24/03/2022	Partial
There was a fire procedure.	Yes
Date of fire risk assessment: 28/07/2022 Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence: The practice conducted a health and safety audit. However, actions recognised did not have any timescales to be completed and it was unclear who was responsible for completing them. After the inspection, the provider provided an updated action plan which evidenced whether each action was completed or in progress and it had responsible person attached to each action.</p>	

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: 25/05/2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: The practice carried out an Infection Prevention and Control (IPC) audit. However, actions recognised in the audit did not have any timescales to be completed and it was unclear who was responsible for completing them. After the inspection, the provider provided an updated action plan, that ensured each action was either completed or was in progress and would be addressed.	

Risks to patients

There were some gaps in 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.	Partial
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 told us there was not always an effective approach to managing staff absences and busy periods. In particular, staffing demands meant that staff felt under pressure during staff absences. The provider was transparent about their struggle to recruit and retain staff. Active recruitment was in place for roles in patient services and nursing.	

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. ¹	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes

There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence: We conducted a review of patient records in relation to the clinical searches identified that care records were managed in line with current guidance.	

Appropriate and safe use of medicines

The practice had some 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 average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.73	0.82	0.82	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). (01/07/2021 to 30/06/2022) (NHSBSA)	8.2%	8.9%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	4.70	5.44	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	96.1‰	102.2‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.43	0.58	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	5.9‰	7.2‰	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).	No
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. ¹	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. ²	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes

Medicines management	Y/N/Partial
Explanation of any answers and additional evidence, including from clinical searches.	
<p>Staff did not always have the appropriate authorisations to administer medicines. Patient Group Directions (PGDs) provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber such as a doctor or a nurse prescriber. We found that 10 PGDs records did not have authorising manager's signature and we found some duplicates of records. After the inspection, the provider told us they have updated the records and all PGDs were corrected and maintained in line with the guidance, however we have not seen the evidence of it. There was a risk that patients did not receive safe care and treatment.</p>	
<p>At the time of the inspection, the practice could not demonstrate the prescribing competence of non-medical prescribers. Non-medical prescribing (NMPs) are used to describe any prescribing completed by a healthcare professional other than a GP. The practice had five NMPs in place at the time of the inspection and we only saw evidence of prescribing auditing for one of them in the last 12 months. After the inspection, the practice provided us with form for non-medical prescriber annual supervision record. This was to ensure all NMPs have a supervision moving forward. However, this was not embedded and completed at the time of the inspection. There was a risk that staff were prescribing medicines outside of their scope of competency and a risk that patients received unsafe care and treatment.</p>	
<p>The provider was able to demonstrate that it was safe to prescribe medicines to patients where specific, frequent monitoring was required. Our remote clinical search of patient records identified some areas where patients were indicated of not receiving the appropriate monitoring. We fed this back to the provider who was able to demonstrate that for these individuals there was appropriate monitoring in place this included existing audits of this patient population. For example, during the clinical searches we found a patient that needed a review of their diabetes. The practice showed us evidence of this review took place and medicines being changed for the benefit of the patient.</p>	

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.	Yes
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Yes
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

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:	115
Number of events that required action:	N/A – not received this information

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

Event	Specific action taken
An incident occurred where data was breached.	<ul style="list-style-type: none"> • Staff member was suspended immediately. • Full investigation of the matter took place (with root cause analysis). • Investigation meeting with staff member. • Guidance sought from Caldicot Guardian. • Appropriate external agencies were informed, including Information Commissioner's Office (ICO) • All staff informed and policy updated to avoid future breaches of data.
Unexpected death occurred in the service for a patient under GP's ongoing care.	<ul style="list-style-type: none"> • Full investigation took place. • NHS multi-agency "end to end" review. • Recruitment of "Young Person Lead", who will support young people who are leaving care.

	<ul style="list-style-type: none"> The CQC were not informed of the death (A statutory notification is required to CQC upon unexpected deaths in line with regulation/guidance if the death occurred while they were actually providing care).
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence: We saw examples of actions taken on recent alerts. The practice kept a log of all safety alerts with dates they were raised and information relating to who it was shared with and responsible owners for actioning.</p>	

Effective

Rating: Good

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

Effective needs assessment, care and treatment

Patients' needs were, 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. ¹	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated. ³	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 prioritised care for their most clinically vulnerable patients.	Yes

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was an appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- There was a mental health practitioner in the practice and the provider was looking to recruit mental health workers to support the mental health support for patients in the practice. The mental health practitioner worked five days a week, offering up to 18 appointments a day (telephone and face-to-face consultations). Their job was to provide assessments, triage, interventions and medication reviews, working in corroboration with secondary care services for people with severe mental illnesses (SMI).
- The practice introduced a nurse-led Lifestyle Clinic twice a week. The clinic mostly focused on patients on the obesity register to help them improve their life and try to create a personal framework to tackle the issue of obesity, looking into the root cause of people's ill health.
- The practice employed a young person care coordinator, who was focused on people aged 11-25 offering face-to-face, telephone and text support. The young people in the practice were encouraged to drop in every day between 9 am and 5 pm and speak to the coordinator. The role consisted of linking in with other services, signposting and offering advice and support.
- The provider obtained individual feedback from patients cared for by the mental health practitioner, young person care coordinator and patients attending Lifestyle Clinics. The recorded feedback was positive.
- There was a social prescribing and wellbeing team in the practice, they were available twice a week. They have created different clinics and support for people, for example, a menopause clinic, and diabetic support.
- There was a digital care coordinator in place, who focused on finding digitally excluded patients in the practice and trying to engage them.
- The practice started the Aging Well project in May 2022 in response to having an aging population. The project focused on frail patients and giving them tools to manage their lives.

Management of people with long term conditions

Findings

- There were no safety concerns found during the review of the clinical records at the practice of people with long-term conditions and high-risk medicines.
- Our clinical records search identified 150 patients with asthma who have been prescribed two or more courses of rescue steroids and had satisfactory reviews in place. We discussed with the provider the need to issue steroid cards for all those patients and the requirement to inform patients of the risks associated with these medicines.
- Our clinical searches found 26 patients with a potential missed diagnoses of diabetes. We reviewed five records in full and found that the appropriate monitoring was in place. This was fed back to the provider and assurances were given through long-term condition management processes that patients on the diabetic register had the ongoing monitoring required in line with National Institute of Care Excellence (NICE) guidelines.
- The search found 11 patients with hypothyroidism who did not receive thyroid function test blood monitoring for 18 months. We reviewed five records in full and discussed these cases with the provider. The provider assured us these patients had the appropriate blood monitoring in place booked in the next few weeks.
- Patients with long-term conditions were offered an annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.

- GPs followed up with patients who had received treatment in a hospital or through out-of-hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Patients with asthma were offered an asthma management plan.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	186	198	93.9%	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 and Improvement)	214	223	96.0%	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 and Improvement)	214	223	96.0%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	214	223	96.0%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	264	274	96.4%	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>

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to	75.2%	N/A	80% Target	Below 80% target

64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	76.7%	61.5%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	74.4%	72.3%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	67.6%	58.5%	55.4%	Tending towards variation (positive)

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.

Any additional evidence or comments

The practice was below the national target of 80% for uptake for cervical cancer screening of eligible people. The practice had a plan in place for the next quarter, starting in January 2023 to emphasise improving the uptake by creating more clinics specific for cervical cancer screening and doing re-calls to eligible patients. However, at the time of the inspection, this project was not started yet.

Monitoring care and treatment

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

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

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

- In November 2021, the practice completed an Attention Deficit Hyperactivity Disorder (ADHD) audit. Healthcare records of 110 patients prescribed ADHD medication were reviewed. As a result, there was a change in the prescribing system for ADHD medication. The change ensured regular recalls were undertaken and information shared with secondary care to improve the quality of care for patients with ADHD.
- In August 2021 the practice completed Direct-Acting Oral Anticoagulants (DOAC – medicines which thin the blood) audit. Patients identified by the audit as not having the required monitoring have been contacted and had relevant tests done to make sure essential care was in place. The learning from the audits had been shared with the clinical team and ongoing monitoring for patients on DOAC is in place. This was second cycle audit following the initial one in 2020.

Effective staffing

The practice was not always 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.	Partial
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Partial
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	No
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:	
<p>The practice had active recruitment in place for clinical staff, including GPs and practice nurses. The staff told us they have felt under pressure. The national shortage of GPs was affecting the practice, however, they took a proactive approach and employed other staff to support the practice population. To combat the shortage of GPs the practice created several other specialist roles: young people coordinator, mental health practitioner, and social prescribing team in order to best support the patients in the practice. Patients were booked in for appointments with these specialists where appropriate to increase appointment availability for those who needed to see a GP.</p> <p>There were some gaps in the mandatory training for staff at the time of the inspection, especially for the HCAs. The provider told us that due to an administrative error the HCAs were not enrolled on all of the mandatory training required for their roles. We have received updated training records post-inspection and most of those records were updated.</p> <p>Staff told us they have not always have protected time to complete mandatory training. The providers told us they would offer overtime for their staff to complete the training after their working hours if needed. At the time of the inspection we could not be assured that the practice had an appropriate system in place to ensure that all staff had appropriate mandatory training in place.</p> <p>The practice could not always demonstrate the competence of staff employed in advanced clinical practice. There was no evidence to demonstrate that Non Medical Prescribers had their competencies assessed.</p>	

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

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

Any additional evidence or comments

The practice had proactive initiatives in place to help patients live healthier lives. There was a dedicated social prescribing team in the practice and a number of events encouraging patients to be a part of the community at the practice. For example, Blandford Park Run, nordic walking, walking group.

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Yes

Responsive

Rating: Not rated

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	Partial
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 (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
Explanation of any answers and additional evidence: <p>We reviewed data from the GP patient survey that showed the practice had lower than average feedback from patients regarding access. For example, only 18.6% of patients who answered the GP patient survey responded positively to how easy it was to get through to someone at the GP practice on the phone.</p> <p>The practice took steps to improve access. A week before the inspection the practice implemented a new telephone system to improve access. The new system sign-posted and informed patients where they were in a queue. The system was embedded and we saw evidence of some improvements. For example, a management dashboard, which showed data regarding the number of answered, missed and abandoned calls, which the provider planned to use to monitor and improve access. This would be achieved through prioritising patient demand and increasing administrative staff covering call handling duties.</p>	

Well-led

Rating: Requires improvement

At our last inspection in July 2016, the service was rated Good for providing well-led services. At this inspection we rated this key question as Requires Improvement, because:

- Safety systems and processes were in place, but were not fully embedded at the time of the inspection.
- We received mixed feedback from staff regarding the leadership and support received. There was a lack of protected time to complete training.
- There was lack of oversight to ensure mandatory training was completed by all staff.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: The leaders reported to us there was an open door policy and they have made themselves available for all staff in the practice. However, not all the staff felt that the leaders were visible and approachable in the practice. Some staff reported that they had not been included in shaping cultures and values of the service and communication.	

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.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: At the time of the inspection, the provider was in the process of developing a new vision and strategy for the Blanford Group (the main surgery and two branch practices). Not all staff members were consulted and informed of the changes made. When we asked members of staff there was a lack of awareness in relation to the practice vision and strategy. The management team told us at the inspection that the vision was still being developed and yet to be shared with all 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

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

Source	Feedback
CQC staff questionnaires forms	<ul style="list-style-type: none"> We received 35 staff surveys during this inspection. We received mixed feedback from the staff. Most staff told us the workload was demanding due to reduced staffing levels. Staff do not receive protected time to complete their training and were feeling under pressure. There was mixed feedback in relation to support received by senior leaders. Staff told us there was an open door policy.

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
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes

Managing risks, issues and performance

There were processes for managing risks, issues and performance, however they were not fully embedded.

	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.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<p>Explanation of any answers and additional evidence: We found evidence of safety systems and processes in place at the time of the inspection. However, for some of these they were incomplete or not fully embedded. For example action plans to risk assessments and staff vaccination status. The provider responded quickly to our feedback promptly revising processes but as these were not in place at the time of our inspection we could not be assured that had we not inspected these improvements would have been made.</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.	Partial
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Partial
<p>Explanation of any answers and additional evidence: We saw examples of audits to improve patient care however, in the examples given there was no further evidence presented to suggest these were to be reviewed again 12 months later to see whether post audit actions had improved patient outcomes.</p> <p>The practice did not inform us of all unexpected deaths that occurred at the practice as statutory notifications. The CQC guidance states the provider must notify us if the death occurred while they were actually providing care. For example, while a patient was in consultation with a healthcare professional, while at the health centre, practice or surgery, or during a home visit. We saw evidence of practice raising it as a significant event an investigated internally but had not submitted the required CQC notification., We could not be assured the provider understood the responsibility to make statutory notifications in those cases.</p>	

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
Staff are supported to work remotely where applicable.	Yes

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	No
Staff views were reflected in the planning and delivery of services.	Partial
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:	
<p>The practice did not have an active Patient Participation Group (PPG) at the time of the inspection. We saw evidence the practice had actively been trying to recruit new members to join the PPG and information was available to patients both in practice and on their website. PPGs are made up of volunteers interested in healthcare issues who meet to decide ways and means of making a positive contribution to the services and facilities offered by the surgery to patients.</p> <p>Staff told us they were not always involved in the planning and delivery of services. The practice had regular team meetings and each team were well informed about the changes happening in their teams. However, staff told us they were not always involved or informed on time about the changes happening in the practice.</p>	

Feedback from Patient Participation Group.

Feedback

As there was not an active PPG in place we were unable to obtain feedback.

Continuous improvement and innovation

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

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

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 SICBL 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 SICBL 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.