

Inspection Evidence Table

Westwood Road Health Centre

Inspection Date: 18/09/2023

Date of data download: 12/09/2023

Overall rating: Good

Safe

Rating: Good

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.	Y
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had appropriate systems and processes to keep people safe from harm and abuse. Staff members we spoke to demonstrated knowledge of what constituted as a safeguarding concern and had awareness on how to raise concerns. Safeguarding incidents were discussed in clinical meetings and shared with other health and social care services where required. There was a system in place to ensure that all staff received an appropriate DBS check. All staff had a DBS check completed when they started working at the practice and were asked to sign a DBS declaration annually which recorded whether there had been changes in their DBS risk status. 	

Following the inspection, the practice updated their DBS policy to ensure they completed another DBS check if a member of staff remained in post for more than 5 years.

Safety systems and processes

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

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We reviewed 5 staff recruitment files which included 3 members of staff and 2 regular locum GPs at the practice. We found that recruitment checks were carried out and there was relevant employment documentation in place. The provider had a process to capture staff immunisation status during the induction process. The practice monitored staff vaccination in line with current guidance. However, we noted there were some gaps in staff immunisation records. Following the inspection, the practice shared a risk assessment to demonstrate that potential risks of infection had been considered for both staff and patients at the surgery. They also shared a comprehensive action plan to evidence the steps that have taken to procure the missing immunisation records. 	

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: August 2023	
There was a fire procedure.	Y
Date of fire risk assessment: June 2023	
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> All staff had completed mandatory fire safety training; however, no designated fire marshals had been trained or appointed. Following the inspection, the practice shared evidence to demonstrate that 3 staff had been designated as fire marshals and additional training had been arranged for them to attend. Fire alarm checks were carried out weekly. There had been a fire evacuation drill in September 2023 A Legionella assessment was undertaken in June 2022. The risk assessment indicated low risk and included actions such as ensuring water temperature monitoring and identification / flushing of 	

infrequently used water outlets. We saw evidence of water temperature monitoring on the day of the inspection.

- Annual PAT testing and calibration of equipment was completed.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: February 2023	
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had an up-to-date infection prevention and control (IPC) policy which was accessible to staff. The last IPC audit was completed in February 2023 and no issues were reported. • Clinical equipment was cleaned on a regular basis and records were maintained. We saw a cleaning log was maintained by the cleaners but found there were a few gaps in recording. However, we observed good standards of cleanliness and hygiene across the practice. • There was a nominated infection prevention and control (IPC) lead and all staff we spoke with knew who the lead was. 	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had access to regular locums who supported the clinical team. 	

- The reception and administrative team consisted of full and part time staff members who were able to cover for sickness and absence.
- The practice nurse was at the surgery 2 days and was supported by a locum nurse. The locum nursing staff did not hold responsibility for the stock management, systems, or processes such as patient group directions updates, infection prevention and control monitoring, immunisation monitoring or cervical screening uptake strategies. However, the practice had plans to recruit a new practice nurse soon there could be more nursing hours available in a week to oversee the key management and clinical functions.
- All staff had completed basic life support training and were aware of how to respond to emergency situations, such as sepsis.
- Emergency medicines and medical equipment was held at the practice and staff were aware of its location.
- All requests for home visits were appropriately triaged by the GP or the paramedic at the practice.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • As part of our inspection, CQC's GP specialist advisor (SpA) undertook clinical searches of the patient's electronic care records. We saw care records were managed in a way to protect patients and demonstrated that care and treatment was being delivered in a safe way. • The practice had an effective system to monitor and track 2-week-wait and non-urgent referrals. • There was a process in place for the management of test results. • The practice offered a health check and medication review for all newly registered patients at the practice. 	

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)	1.00	0.82	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)	10.8%	8.2%	7.8%	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 (01/01/2023 to 30/06/2023) (NHSBSA)	5.02	5.46	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	111.6‰	88.3‰	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)	0.39	0.39	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	6.4‰	6.0‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	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).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	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.	Y
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.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Partial
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> During the review of the clinical system, we reviewed patients who had been prescribed a disease-modifying antirheumatic drug (DMARD). The searches indicated that patients were managed in line with guidance. For example, there were 17 patients prescribed methotrexate (a drug used to treat inflammatory autoimmune conditions like rheumatoid arthritis), and all 17 patients had been monitored appropriately. The clinical searches identified 522 patients who had been prescribed an ACE inhibitor or Angiotensin II receptor blocker (medicines used to treat high blood pressure and heart failure which require regular monitoring) in the 12 months preceding the search. We saw 7 were coded as not having received the necessary monitoring on the clinical system. We reviewed all 7 patient records and found clear and comprehensive documentation of clinically appropriate reasons as to why the patients appeared on this search. We did not identify any risk to patients' wellbeing. Appropriate medicines reviews had been undertaken by the practice and these were of a good quality and included evidence of detailed discussions with patients. Blank prescription stationary was stored securely, and a process was in place to track prescriptions through the practice. The practice had a policy of recording fridge temperatures twice daily. We found gaps in the temperature recordings of the vaccine fridges and temperature checks were not being carried out in line with the practice's own policy. Following the inspection, the practice shared evidence that a new data logger had been purchased for the practice in line with national guidance. Patient Group Directions (PGD) were in place but had not been authorised appropriately. (A PGD contains written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). These had not been signed off appropriately to authorise staff to administer vaccines in line with national guidance. A member of the staff who had been giving vaccines had signed the PGD after it was authorised. This meant the member of staff was not authorised to work under the PGD. However, following the feedback the practice rectified these on the day of the onsite inspection. 	

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.	Y
Number of events recorded in last 12 months: 5	
Number of events that required action: 5	
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was a significant event policy in place and accessible to all staff. Staff told us they were aware of the process to report an incident and felt confident to do so. We saw in evidence of meeting minutes that significant events were discussed and documented. 	

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

Event	Specific action taken
<ul style="list-style-type: none"> Several blood results reported unexpectedly raised potassium levels 	The practice investigated the incident which was highlighted by a number of blood results that reported raised potassium levels. It was found that there were delays with transport that led to this. Each patient was contacted with explanation and their blood results were repeated.
<ul style="list-style-type: none"> Unlabelled patient specimen was dropped off at the surgery. 	Patient placed an unlabelled urine specimen in the drop off basket without informing the reception staff. As a result, an action was taken to move the drop-off basket behind the reception desk, so patients would have to ask to put the specimen in the basket and the error could be avoided. Learning was shared with all staff to ensure the incident did not happen again.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Our clinical searches indicated that safety alerts had been responded to appropriately. During our clinical searches, we reviewed Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts and saw that they had been managed appropriately. Our searches identified 103 patients prescribed SLGT-2 inhibitors (used for the treatment of type 2 diabetes) and we reviewed 5 of these patient records. We found all these patients had been advised of the MHRA safety alert highlighting the risk that taking this medication can be associated with developing Fournier's gangrene (a rare but serious and potentially life-threatening infection). 	

Effective

Rating: Good

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice used a range of clinical templates to support the management of patients' conditions, which linked in with the latest clinical guidance. • Our clinical searches and records reviews indicated that patients' ongoing needs and medicine reviews were consistently monitored and documented to demonstrate that patients were assessed appropriately. • Searches of the clinical system showed 19 patients with asthma had been prescribed 2 or more courses of rescue steroids in the past 12 months. We reviewed a random sample of 5 patient records and found the practice complied with recommended guidelines and contacted patients to discuss their medication and asthma after being prescribing steroids. 	

Effective care for the practice population

Findings

- 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.
- The practice has 11 patients on the learning disability register and all patients were offered an annual health check in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- 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.

Management of people with long term conditions

Findings

We carried out remote searches of the practice's clinical records in relation to some long term conditions and found:

- All patients we reviewed with long term conditions such as asthma, diabetes and hypothyroidism were monitored and followed up in line with national guidelines and there was evidence of completed care plans.
- We found that asthma patients had received effective annual reviews and were followed up after an acute exacerbation of asthma in line with national guidance to ensure they received appropriate care.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- The practice followed up patients who had received treatment in hospital or through out of hours services.
- Patients with long term conditions were invited for a review annually. The practice offered longer appointments for patients with severe mental illness (SMI) reviews and learning disability patients.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	55	56	98.2%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	54	60	90.0%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	53	60	88.3%	Below 90% minimum
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)	54	60	90.0%	Met 90% minimum
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)	45	51	88.2%	Below 90% minimum

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

Any additional evidence or comments

- Childhood immunisations were carried out in line with the national childhood vaccination programme. The uptake rates were below minimum World Health Organisation targets of 90% for 2 out of 5 indicators however, this equated to only 1 unvaccinated child for each indicator.
- The practice had processes in place to contact parents or carers to remind them about appointments and to follow up non-attenders for immunisation.
- When parents declined immunisations for their child, they were asked to have a consultation with staff before signing a disclaimer so that staff could give them more information on the importance of having the immunisation.
- The practice had small numbers of patients that were preventing them from meeting the World Health Organisation (WHO) targets.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	66.3%	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)	66.4%	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)	73.0%	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)	54.8%	53.3%	54.9%	No statistical variation

Any additional evidence or comments

- The practice encouraged patients to attend cancer screening appointments. Early morning clinics were held, and cervical screening appointments were available every Wednesday and Thursday with the nurse at the practice.
- Staff told us that opportunistic appointments were offered to improve uptake among patients.
- The practice management team undertook reviews of practice performance against the Quality and Outcomes Framework (QOF).

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>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years.</p> <p>The practice carried out repeated clinical audits to review and monitor the appropriateness. The 2-cycle audits could evidence where changes or improvements had been made:</p> <p>An audit was carried out to review compliance for management of Urinary tract infection (UTI) in over 65s. the audit reviewed 10 patients and found 90% of patients received the right dose/frequency dose/course and length of treatment. Following the audit, the practice took action to ensure they did not dipstick patients over 65 as they become unreliable with increasing age. The audit addressed how the urine samples were managed and reduced unnecessary urine dipping.</p> <p>All staff including locum GPs, were provided with information about this UTI audit and information was displayed in each consultation room for guidance.</p>	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff at the practice had access to regular appraisals and clinical supervision. • There was a system was in place to monitor and review staff training and we saw high levels of completion rates for training specified as mandatory. 	

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
Explanation of any answers and additional evidence: <p>The practice worked closely with other organisations to ensure continuity of care for its patients for example with health visitors, district nurses and community midwives.</p>	

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 had access to social prescribing through the Primary Care Network. Social prescribers help patients and their carers with information and signposting to community and advocacy services.
- Health promotion information was provided on the practice website and enabled patients to access a range of information. This included information on diabetes, cervical screening, weight management and dementia.

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
<ul style="list-style-type: none"> • All staff including the locum GPs had undertaken Mental Capacity Act (2005) training. • We reviewed the records of 3 patients where a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions had been recorded and saw that comprehensive records had been maintained, and this included assessment of the patient's mental capacity. 	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence:	

- GPs and the PCN paramedic undertook home visits to support housebound and end of life care patients. Home visits were arranged for housebound patients to ensure they had annual check-ups, blood pressure and blood tests carried out. We were told that 60 home visits were made in the last 12 months by the practice staff.
- Staff we spoke with displayed the values of the practice and treated patients with kindness, respect, and compassion.

Patient feedback	
Source	Feedback
.NHS UK	The practice had received 1 review in the last 12 months. The feedback suggested they were listened to and treated with respect, dignity and kindness.

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)	86.8%	85.7%	85.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2023 to 30/04/2023)	82.4%	84.2%	83.8%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2023 to 30/04/2023)	92.7%	93.1%	93.0%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	75.4%	72.4%	71.3%	No statistical variation
Any additional evidence				
The GP patient survey data for 2023 indicated that patient satisfaction in relation to care was in line with or better than local and national averages.				

	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y

Any additional evidence
During the inspection, we reviewed the outcomes of NHS Friends and Family Test responses from July, August and September 2023. There were 72 responses received in August 2023 and most comments suggested patients were treated with care and concern and had confidence and trust in the healthcare professional they saw or spoke to.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence:	
Easy read and pictorial materials were available.	

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 stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023)	91.0%	91.9%	90.3%	No statistical variation
Any additional evidence or comments				
	Y/N/Partial			
Interpretation services were available for patients who did not have English as a first language.	Y			
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y			

Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Information in multiple languages was available and staff had access to interpretation services. The practice had a hearing loop in place to support patients with hearing difficulties. 	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 54 of their patients were carers. This was approximately 1% of their patient list.
How the practice supported carers (including young carers).	The practice offered health checks and flu immunisations to all carers. The practice was working to promote the identification of carers, there was an easily accessible form on the practice website to register as a carer.
How the practice supported recently bereaved patients.	Staff told us bereavement support was available, a GP /social prescriber appointment was offered to families of bereaved patients.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive

Rating: Good

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice provided extended hours appointments on Mondays and Thursdays until 8.30pm. Early morning appointments were available with the practice nurse 2 days a week. The surgery provided access for wheelchairs as well as a designated bay for disabled parking. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	7.30am – 8.30pm
Tuesday	7.30am – 6.30pm
Wednesday	7.30am – 6.30pm
Thursday	7.30am – 8.30pm
Friday	7.30am – 6.30pm
Appointments available:	
Monday	8.00am – 8.30pm
Tuesday	8.00am – 6.30pm
Wednesday	7.30 am – 6.30pm
Thursday	7.30am – 8.30pm
Friday	8.00am – 6.30pm

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 had accessible toilets for people with limited mobility and there were designated baby changing facilities.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Early morning and late evening appointments were available for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- 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 such as longer appointments. The practice held a register of patients living in vulnerable circumstances including housebound patients and those with a learning disability.
- All newly registered patients were offered an introductory appointment and medication review within the first month.
- All vulnerable patients received a phone call after their attendance at A&E or Out of hours service.
- The practice was open until 8.30pm twice a week.

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"> • Appointments were offered via telephone and on a face-to-face basis. • GP appointments could be booked on the day and urgent appointments were available throughout the day for patients who needed them. • The practice had identified patients who were vulnerable or who would have difficulties accessing the service and had flagged them on their system. 	

- Patients requesting an appointment were triaged by a clinician and were booked to see the most appropriate clinician for their presenting condition.
- In addition to appointments with GPs, the practice also offered appointments with practice nurses, a health care assistant, pharmacist, care coordinator, paramedic, social prescriber and a phlebotomist.

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)	58.0%	N/A	49.6%	No statistical variation
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)	63.0%	53.8%	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)	59.3%	51.8%	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)	77.8%	70.3%	72.0%	No statistical variation

Any additional evidence

The practice was also collecting patient feedback through the Friends and Family test. Feedback from patients was positive, about staff being friendly and helpful, and excellent care provided by the practice.

Source	Feedback
Patient Participation Group (PPG) members	The practice had an active and supportive PPG who spoke highly of the leadership team. They told us the leadership team was open and honest and, responded to feedback positively. PPG members felt valued and included in the development of practice.

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.	8
Number of complaints we examined.	8
Number of complaints we examined that were satisfactorily handled in a timely way.	8
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
Explanation of any answers and additional evidence: The complaint log was maintained, and we saw the complaint system promoted candour. However, they did not have a process to record learning from complaints and ensure this was shared with staff and resulted in changes where necessary.	

Example(s) of learning from complaints.

Complaint	Specific Action Taken
A patient complained that they were unhappy with the GP and found them rude.	The practice manager investigated the complaint, and an apology was given to the patient. The complaint was brought to the concerned GP's attention and was discussed at the next clinical meeting. The patient was advised to reach out if they were unhappy with the outcome of the complaint.

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels

	Y/N/Partial
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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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff spoke highly of the leadership at the practice. We were told that the leaders were visible and approachable. • The leadership team was open about the challenges they faced with staff recruitment. • The practice was responsive and proactive to feedback during the inspection process and acted upon our findings and feedback immediately. • Most staff at the practice had been with the surgery for over a decade, and felt they were supported by the leaders and peers at the surgery. • The practice ownership was a single handed GP structure and there were plans to recruit suitable partners to join the practice, however these were in early stages. • The practice had access to regular long term locums GP who worked at the practice on the same day each week ensuring continuity of care for patients. 	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff we spoke with shared the provider's vision and understood their role in achieving it. • The provider had plans to improve the service further. The leaders had plans to offer new services to increase capacity and access, through the PCN, such as the mental health nurse and setting up a woman's health hub 	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Staff well-being was discussed as part of the appraisal process.• The practice recently appointed an external person as Freedom to speak up guardian, to support staff to raise concerns.• Staff told us they received consistent support from the GP and the practice manager.	

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

Source	Feedback
Staff Feedback	Prior to the inspection we gave all staff the opportunity to provide written feedback anonymously about their experience of working at the practice. We received feedback from 5 members of staff employed at the practice. All staff expressed a positive experience of working at the practice. Staff felt they were treated equally and had prompt access to the leaders and any advice they needed.

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.	Partial
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
Explanation of any answers and additional evidence: The practice had a governance framework, however, there was a lack of monitoring in specific areas: <ul style="list-style-type: none">• The provider did not have an effective oversight of fridge temperature monitoring as we found a few gaps in their recording. We saw that the practice was not following their cold chain monitoring policy. However, following the inspection, the practice purchased a data logger and told us they would review their processes.• We found that the Patient Group Directions (PGD) were not appropriately authorised to administer vaccines. However, these were rectified on the day of the inspection.	

Managing risks, issues and performance

There was a 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice told us that informal reviews of their prescribing and consultations took place on an ad-hoc basis for the locum GPs at the practice, however we were not provided evidence of this. During the inspection, the management recognised this as an area for improvement and were reviewing actions going forward.• The practice had a clear process of managing risks and these were discussed during the clinical and all staff meetings.	

- The practice had implemented processes to monitor clinical performance and quality of care within the practice using benchmarks such as Quality Outcome Framework (QOF) , clinical audits, complaints, compliments, and national patient survey results.

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: The practice used data to benchmark their outcomes against other practices in their primary care network. We saw evidence of annual appraisals to monitor staff performance at the practice.	

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 held multi-disciplinary meetings with other health professionals for patients assessed as end of life, vulnerable and with frailties. 	

Engagement with patients, the public, staff and external partners

The practice involved 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The provider worked with other practices within their PCN to provide a wider range of services.• The practice had an active Patient Participation Group, the last meeting was held with members in March 2023. The feedback from the meeting was considered and responded to. For example, as a result of feedback received from the PPG members, the length of the recorded telephone message was shortened for patients phoning the surgery.• Staff feedback highlighted the ethos of working together as a team.	

Continuous improvement and innovation

There were little evidence of 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Staff told us they had protected time and they were able to set learning objectives during their yearly appraisals.• The practice undertook regular clinical and non-clinical audits to support service improvement.• During the inspection, we found the leadership team to be extremely proactive and responsive. They took immediate action to make improvements and provided evidence to show what actions had been implemented.• The practice made use of feedback from patients and PPG members to make improvements.	

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.