

# Care Quality Commission

## Inspection Evidence Table

### Whitby Health Partnership (1-546082353)

Inspection date: 21 July 2022

Date of data download: 13 July 2022

## Overall rating: Inspected but not rated

Safe

Rating: Inspected but not rated

### 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
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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>• Receptionists were trained and supported in their role. We saw there were written protocols to follow to enable them to allocate patients to the correct clinician to assess their needs and to identify if a patients presenting symptoms needed to be prioritised.</li><li>• The procedure followed by the reception team also enabled them to identify any patients who may benefit from being signposted to an alternative resource such as a community pharmacy or a physiotherapist. This meant the provider could more effectively manage its capacity for clinical appointments.</li><li>• The appointment system was overseen by a non-clinical manager daily to ensure that it was used to its full potential to meet the needs of patients.</li><li>• We observed the reception team managing initial telephone calls from patients requesting an appointment with a clinician. The team followed the procedures in place and spoke to patients in a caring and compassionate manner.</li><li>• Patients could complete an electronic consultation (E-Consult). There was a process for a clinical member of staff to respond to these within 48 hours. E-Consults were initially reviewed</li></ul>	

by a non-clinical member of staff and any indicating a priority need were directed to a clinician immediately.

- There was a procedure for reception staff to follow to identify patients presenting with symptoms of Covid-19. Changes had been made to the service to support patients presenting with symptoms of Covid-19 and to minimise the risks of Covid-19 to patients and staff.
- The provider managed the time of the reception team to enable them to effectively meet the needs of patients. For example, patients were directed to contact the practice after a certain time for non-appointment requests.

**Information to deliver safe care and treatment**

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

	Y/N/Partial
There was a documented approach to the management of test results, and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial

Explanation of any answers and additional evidence:

- We reviewed the system in place to manage incoming correspondence such as patient test results and correspondence received from hospital and the out of hours service. There was a clear process in place to ensure this was actioned by a clinical member of staff or the medicines management team as required. Non-clinical staff followed a written protocol and correspondence was prioritised according to risk to patients.
- There were arrangements in place to train and support staff new to the role of processing incoming information about patients. This was confirmed by the staff we spoke to.
- The provider told us that they currently had staff shortfalls as a result of unplanned absences and staff holidays. As a result, this had impacted on the administrative team and there was a backlog of correspondence to be processed. The provider told us they were addressing this through staff working over-time. There was also a system to prioritise all incoming correspondence so only routine correspondence was waiting to be processed. We reviewed records which confirmed this. This backlog was being closely monitored by the provider.
- The provider told us they had a sufficient number of non-clinical staff. However, some non-clinical staff were new and were in training. This impacted on their staff resources to manage incoming

correspondence. In preparation for future absences these staff were being trained so they could multi-task and cover a variety of non-clinical roles.

- An informal system was in place to check that non-clinical staff were processing incoming correspondence correctly. The provider told us that they were planning to formalise this and to introduce specific performance indicators for the processing of incoming correspondence. The provider had recently employed a member of staff to assist with this.
- Some staff told us that they understood the need to multi-task so that they could cover absences. However, they would like to be part of a dedicated team to ensure consistency and continuity.

### Appropriate and safe use of medicines

**The practice had systems for the appropriate and safe use of medicines.**

Medicines management	Y/N/Partial
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• We reviewed the systems in place to manage changes to patients' medicines including changes made by other services. Information about changes to medication such as hospital discharge summaries were reviewed by the medicines management team which included a pharmacist and a pharmacy technician. Any changes made were then reviewed by a GP to ensure they were correct prior to a prescription being issued. Any changes made were documented in patients records. For complex medication issues there was a process for the GP to be sent the correspondence directly to review and make changes. There was an informal process in place to periodically check that this system was working effectively. The provider told us that they were planning to formalise this.</li> <li>• Due to unplanned staff absences the provider told us that there was a backlog of six days for processing correspondence relating to changes to patient's medication. The provider told us they were addressing this through staff working over-time and obtaining assistance from staff employed by the Primary Care Network (PCN). There was also a system to prioritise all incoming information relating to medication changes to ensure urgent requests were dealt with first. We reviewed records which confirmed this. This backlog was being closely monitored by the provider.</li> <li>• The provider was training a further staff member to assist with the processing of management of information about changes to patient's medicines.</li> </ul>	

