

# Care Quality Commission

## Inspection Evidence Table

### Wyke Regis and Lanehouse Medical Practice (1-564490980)

Inspection date: 12 August 2022

Date of data download: 22 July 2022

## Overall rating: Requires Improvement

### Safe

### Rating: Requires Improvement

We have rated the practice as requires improvement for providing safe services as we found the management of medicines needed strengthening.

#### 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
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
Explanation of any answers and additional evidence: All staff were required to complete regular safeguarding training as required in the intercollegiate guidance. The training data reviewed during our inspection showed three clinicians had not completed training to the level three standard. Following the inspection, the practice sent us evidence to show these clinicians had completed the training.	

Recruitment systems	Y/N/Partial
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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.	Yes

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: February 2022	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: January 2021 Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: The action plan from the risk assessment undertaken in January 2021 highlighted 12 actions, across the three sites to be completed. We saw nine of these had been completed. For the remaining three, which included all fire doors needing hinges replacing with fire rated hinges and some doors needing intumescent strip replacing due to poor fitting, the work had been booked for September 2022.	

## 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.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 5 August 2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: We walked around the building on the day of inspection and found it to be clean and hygienic throughout. One of the practice nurses took the lead, undertaking audits and ensuring all staff were up to date with the most recent guidance and information. All staff were required to undertake annual training on infection prevention and control. However, training data reviewed during our inspection showed only 18 (72%) out of 25 clinical staff had completed the training.	

## Risks to patients

### There were 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.	Yes

There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
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	Partial
<p>Explanation of any answers and additional evidence:</p> <p>We found although the majority of staff had received training in sepsis awareness only 12 (38%) of 38 staff members had undertaken basic life support training so we could not be assured that staff could respond to emergency situations safely.</p> <p>We found there was limited clinical and administrative support due to long term sickness and staff vacancies. The provider was aware of this and told us they were actively recruiting and looking at ways to support their clinical staff. A new role was being developed; administrative staff were undergoing training as Gp assistants (GpA) to support the GPs.</p> <p>The GpA role at Wyke Regis and Stonehouse Lane was to monitor patient e consults requests, if further information was needed the GpA would telephone the patient and request this prior to the patient seeing their GP. They would also assist the GP with any follow up actions, for example booking further appointments or making referrals.</p>	

## Information to deliver safe care and treatment

**Staff did not always have the information they needed to deliver safe care and treatment.**

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
Explanation of any answers and additional evidence:	

Correspondence and blood tests results were collectively processed by the locality team in the primary care network (PCN) for all five practices within the PCN. Our clinical searches had highlighted over 5,000 tasks on the PCN system.

Evidence we reviewed the following day on our onsite part of the inspection found there were a total of 1,034 open tasks for Wyke Regis and Stonehouse Lane Surgery. Tasks are used as a form of communication for example, tasks can include reminders to individual team members, reminders to call patients back or to follow up blood tests or referrals. Of the 1,034 tasks 99 were assigned to doctors' groups, there was no urgent tasks awaiting to be actioned.

## Appropriate and safe use of medicines

**The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation**

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.82	0.79	0.79	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). (01/04/2021 to 31/03/2022) (NHSBSA)	7.8%	9.2%	8.8%	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 (01/10/2021 to 31/03/2022) (NHSBSA)	4.94	5.42	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	124.6‰	102.5‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.85	0.58	0.60	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) <small>(NHSBSA)</small>	5.5‰	7.3‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	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.	Partial
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.	Partial
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.	NA
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
Explanation of any answers and additional evidence:	

## Medicines management

Y/N/Partial

Non-medical prescribers and allied health care professionals had access to ongoing daily support from GPs. However, feedback from staff informed us that due to staffing pressures this support was not always available. Clinical staff met daily for case discussion although regular reviews of their prescribing practice was not undertaken.

Allied health professionals had access to monthly tutorial sessions which also enabled clinical supervision and case discussion.

As part of our inspection a number of set clinical searches were undertaken by a CQC GP specialist advisor without visiting the practice. The records of patients prescribed certain high-risk medicines were checked to ensure the required monitoring was taking place. These searches were visible to the practice. The clinical searches found the system for ensuring patients had the required monitoring when prescribed certain medicines was not effective. We found some patients had not had the appropriate monitoring and review for medicines prescribed. For example:

One search reviewed the prescribing of a high risk medicine primarily used to treat rheumatoid arthritis. Our search identified six patients who were prescribed this medicine, with four patients identified as not receiving all recommended monitoring tests. However, one patient was seen to have an upcoming appointment booked to review their medication.

Patients prescribed blood thinning medicines should have regular checks of their kidney function and calculation of their creatine clearance level to ensure they are being prescribed the appropriate dose, and whether it was appropriate for the patient to remain on the treatment. From the search of the practice clinical system we found 475 patients on this type of medication with 288 (60%) whom had not received the appropriate reviews.

Following the inspection, the provider sent us an action plan detailing the contact made with the patient and the date for a follow up review appointment.

## 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:	17
Number of events that required action:	13
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a system for identifying and recording significant events and demonstrated that there were actions and learning associated with these. An overall trend analysis of significant events was built into their system, and they told us they were reviewed. The practice showed us that they discussed these in meetings and learning was shared. There was an incident policy in place.</p> <p>The practice also recorded positive feedback from patients, and this was shared with all staff.</p>	

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

Event	Specific action taken
A referral letter had been in the post tray for three days, it should have been processed within 48hrs of arriving.	A restructure of the admin team took place and processes had been put in place to ensure this did not happen again. No harm came to the patient.
Two smears were taken during a morning. Unfortunately, both samples were labelled with the same patient information. This resulted in neither sample being processed as it was unclear who was who's.	The cervical smear policy was reviewed with the lead nurse. The incident was discussed, and all staff were reminded of the importance of checking patient details before attaching labels to sample pots.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>There was a system in place to record and manage safety alerts. A record of alerts and recalls, was held in the PCN Pharmacy team's folder, on a central server. If the practice needed to action an alert, the PCN Pharmacy team were responsible for carrying out the relevant searches of the patient's records. Once the patients had been highlighted, they would task the usual GP if a clinical decision is required to action the alert. A list of patients and the required actions would then be emailed to the allocated practice colleagues.</p>	

However, we found 45 patients appeared to have been co-prescribed Clopidogrel and Omeprazole together. Omeprazole reduces the effectiveness of taking Clopidogrel to prevent cardiovascular disease. Of the five records reviewed, five of these patients were taking Clopidogrel and Omeprazole together despite a safety alert for this being issued in 2014. There was no evidence this had been identified during medication reviews. The medicine had not been altered and we could not be reassured the risks of the combination had been discussed with the patient.



## Effective

## Rating: Requires Improvement

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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes

### Effective care for the practice population

Findings
<ul style="list-style-type: none"><li>• 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.</li><li>• Health checks, including frailty assessments, were offered to patients over 75 years of age.</li><li>• Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.</li><li>• The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.</li><li>• 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.</li><li>• Additional nurse appointments were available from 7.30am on Tuesday and Thursday mornings and two Saturdays a month for school age children so that they did not need to miss school.</li></ul>

- The practice had introduced the duty clinical team to manage on the day demand. The team is made up of allied health professionals (paramedic, advanced nurse practitioners and supported by a duty doctor)
- 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.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to the practices' mental health practitioner for assessment and treatment then referred to appropriate services if required.

## Management of people with long term conditions

### Findings

- Our review of clinical records identified that patients with long-term conditions were not always being managed at PCN level effectively or were having regular long-term condition reviews. For example:
- 45 out of 566 patients with hypothyroidism (a condition where the thyroid gland is underactive and not producing enough hormone) had not had their thyroid function monitored in the past 18 months.
- The clinical searches identified nine patients with a potentially missed diagnosis of diabetes in the practice. We looked at five electronic records and found that a review plan had been made with initial result but no evidence that follow up had taken place. One record showed a diagnosis should have been made and follow up appointment arranged.
- A total of 90 patients with asthma had been prescribed two or more courses of rescue steroids in the last year. (Steroids are used to reduce inflammation and in an asthma attack, assist in opening up airways). We reviewed the records for five of these patients and found that two of the patients had not received a review to ensure the treatment was effective and the patients did not require further interventions.
- Following the inspection, the practice sent us an action plan stating these patients were on the locality spreadsheet to be contacted for review and in some cases the practice had contacted the patient and a follow up appointment had been made.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in 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.
- 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.

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)	108	112	96.4%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	115	121	95.0%	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)	115	121	95.0%	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)	114	121	94.2%	Met 90% minimum
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)	135	144	93.8%	Met 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>

Cancer Indicators	Practice	CCG 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 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	75.7%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	27.9%	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)	73.8%	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)	50.0%	58.5%	55.4%	No statistical variation

#### Any additional evidence or comments

The cervical screening uptake rate was below the national target of 80% despite appointments being available throughout the pandemic. The practice told us access was not a barrier to accessing this service. Sample takers were available throughout the day. Females were also able to book during extended access, which provided early mornings and weekend appointments.

## Monitoring care and treatment

**The practice had a 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.	Partial
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

The practice had carried out a range of audits and reviews to identify and monitor any quality improvements. Examples sent to us included reviews for skin cancer diagnosis, review of two week referrals, and treatment for patients diagnosed with high blood pressure. However, there was no evidence of specific actions being taken to improve patient care or review to demonstrate assurance that improvements were embedded in practice.

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence:  The practice manager confirmed that a few (five out of 33) staff appraisals were behind schedule. We heard that the challenges presented by the pandemic and the demands placed on the GP practice had prevented the delivery of these staff appraisals. However, the practice manager was in the process of implementing a practice action plan to address this.  After the inspection the practice manager sent us a schedule detailing planned staff appraisal for each of these team members.	

## 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.	Partial
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence: We found potential missed diagnoses of diabetes through the completed clinical searches undertaken.  The practice had access to a social prescriber, first contact physiotherapist and mental health practitioner, via the primary care network (PCN). This enabled patients to get support to improve their health and wellbeing.	

## 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.	Yes
Explanation of any answers and additional evidence: We examined two patient's DNACPR records. These were recorded appropriately and demonstrated that the patients and/or their carers were involved and agreed with the DNACPR.	

## Responsive

Rating: Not Rated

### Access to the service

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

*The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.*

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
Explanation of any answers and additional evidence: The practice had recently introduced an on the day service to meet the needs of patients requesting same day appointments. The team offered telephone consultations and face to face appointments.	



## Well-led

**Rating: Good**

### Leadership capacity and capability

**Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence:	
The practice was aware of the current recruitment difficulties and had looked to developing allied health professional roles to support the GP team, for example paramedics to work as part of the on the day team.	
The practice leaders were knowledgeable about issues and priorities relating to the quality and future of community services. They understood the challenges affecting their patient population and the local area population and promoted patient involvement in developing and shaping the services.	
The GP told us that the recent pandemic had resulted in them 'firefighting' constant challenges leading to a service that had been reactive. The focus going forward was to become more proactive and a restoration action plan was being implemented at the time of this visit. Evidence of this was found during our clinical searches and subsequent action plans to address those issues.	
Staff feedback forms received by CQC indicated that there was good teamwork and that staff felt supported. However, concerns regarding staffing in reception were mentioned a number of times.	

### Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes

Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes

## 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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>Staff we spoke to explained that their wellbeing had become affected due to increased workloads and staff shortages. The leadership team explained they were aware that staff had worked through a difficult period and were actively recruiting new staff members.</p> <p>The practice management team valued their staff and adopted a nurturing and supportive environment, maintaining an ethos of respect for all staff. However, whilst staff were encouraged to, not all staff felt able to raise concerns.</p>	

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

Source	Feedback
Staff Questionnaires	Staff felt more clinical staff were needed to support the patient list size. Staff we spoke with during interviews told us they were happy working at the practice and felt supported within their role.

## 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

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	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
Explanation of any answers and additional evidence:	
Staff were able to identify and report significant events. However, there was limited information to demonstrate that learning had been identified and any actions taken were monitored to make sure they were effective. Clinical and staff meetings had been suspended due to Covid, although these were planned to re commence in September. This meant we found limited evidence to show that learning had been identified and shared with staff.	
Our clinical searches found that not all patients had received the appropriate monitoring required as part of their management of their condition. However, the practice demonstrated to us that they were responsive to our findings and had created a plan in place to address these this included evidence that between the searches and onsite element of inspection many patients had been contacted to come in for an appointment to review their care and treatment.	

### The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes

Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had introduced Gp assistants who support GPs with routine clinical administration during appointments and carry out some basic clinical duties. The Gp assistants enable the GP to spend time with patients and improve access to appointments.</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.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes

### 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
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	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.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes

Feedback from Patient Participation Group.

Feedback
The practice had an active patient participation group. We met with the chair of the Patient Participation Group (PPG) for the practice. They told us the practice were committed to working with the PPG to improve patient experience and described how they had assisted the practice during the pandemic and how they were now eager to encourage new members to join the group.

Any additional evidence
Following the poor results of a locality patient survey the practice, in conjunction with the PPG, took the decision in March 2022 to write a letter to all their patients over the age of 16 explaining all of changes within the practice and the reasons behind these changes. In July 2022 they sent a patient survey to 4000 patients, all of whom had attended the practice within the past six weeks. Changes made as a result of this survey included the monitoring of telephone calls and ensuring additional staff were allocated to cover the phone during busy periods and the introduction of a digital champion in the practice every Thursday morning to support/help patients.

## Continuous improvement and innovation

**There was 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.	Partial
Explanation of any answers and additional evidence:  The practice was part of the local primary care network with other local GP practices working together to improve and provide services for patients.	

## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

## Glossary of terms used in the data.

- COPD:** Chronic Obstructive Pulmonary Disease.
- 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.