

Care Quality Commission

Inspection Evidence Table

Leatside Health Centre (1-589893016)

Inspection date: 28 February to 1 March 2022

Date of data download: 10 February 2022

Overall rating: Good

Safe Improvement

Rating:

Requires

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.	Yes
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: <ul style="list-style-type: none">Staff spoke confidently of how and when to raise safeguarding concerns. Staff explained which local agencies could be contacted and the process used to report concerns. All staff were trained to the appropriate level.Safeguarding concerns were communicated to the out of hours service by secure email and added to the patient record. Summary care records were updated and shared where appropriate.Older children moving into adulthood were added to the adult safeguarding register and staff were aware of the transition challenges this involved and how to support patients.During our review of records, we saw appropriate DBS checks had been completed and recorded. These were renewed on a three yearly cycle.Daily meetings were held with community teams and fed back to the practice staff.	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> Any children who did not attend a prebooked practice or hospital appointment were brought to the attention of the safeguarding lead to follow up with a call or text message. All adult safeguarding concerns were brought to the attention of lead clinicians, specifically to highlight any documents received or conversations following patient contact. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We saw there was an appropriate recruitment policy that set out the standards the practice followed when recruiting clinical and non-clinical staff. The practice had a comprehensive locum pack to advise locum GPs of the practices process and procedures. We reviewed the recruitment files and processes followed for three of the most recently recruited members of staff and found the practice had completed relevant and appropriate recruitment checks. This included the process to record staff vaccination and immunisations which had been revised. All existing staff had provided evidence of individual records of vaccination and immunisation and for all new members of staff, the recruitment process now included a section on vaccinations and immunisations. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 31 January 2022	Yes
There was a fire procedure. Date of fire risk assessment: 15 February 2022	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Fire wardens were in place and appropriately trained, deputies were also nominated to cover for absences. Following the latest fire risk assessment in January 2022, no specific actions were identified. However, it was noted that the fire evacuation procedure had been updated recently and had been reissued to all staff. The health and safety risk assessment identified a number of actions to be completed within a six month period. For example, ensuring that all staff had been issued with a health and safety handbook. This had been completed and staff we spoke with confirmed this. A Legionella risk assessment was scheduled to be carried out in April 2022. Local checks were carried out weekly and documented. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit: January 2022	
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: <ul style="list-style-type: none">• All new staff received infection prevention and control (IPC) training as part of their induction.• From the infection control audits, we saw a high level of compliance to IPC standards and this aligned to practice specific policies and standard operating procedures to manage the COVID-19 pandemic. We also saw the practice had completed a variety of infection risk assessments throughout the COVID-19 pandemic.• Regular handwashing audits were completed for all staff to check technique and confirmed compliance.• Clinical waste was stored appropriately and there was a collection contract in place.	

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.	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.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Planned absence cover was well managed. Reception and administration staff had a text messaging group set up to notify each other if urgent cover was required and if necessary, the management team covered staff absences.• The practice used telephone data and the online patient triage system to review busy periods and peaks in activity to ensure the number of required staff and the skill mix aligned to patient levels and safe staff workload.	

- Reception/ administrative cover and call levels were discussed at staff meetings.
- New staff had a detailed induction including shadowing other team members.
- Sepsis posters were in all staff areas and staff were able to describe what they would look for if a patient became unwell and how they would escalate any concerns.
- All staff had completed sepsis training appropriate to their role.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment, however systems needed to be improved and embedded.

	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: <ul style="list-style-type: none"> • Practice staff shared information via community teams' monthly meetings and a special direct contact number for the practice was available to community staff, for example, district nurses and paramedics that bypassed the main practice telephone system which meant they could easily get through to practice staff. • There was a dedicated team to manage referrals to specialist services. Staff booked appointments, liaising with patients and checked post appointment that the patient had attended. • All referrals were held on a centralised tracking document to ensure that no referrals, appointments or test results were missed. • When test results were received, administrative staff would send an electronic task to the relevant GP to action. • Clinical staff told us they reviewed results daily, from the hospital system, however, these results were not always recorded in the patient notes. Immediately following the inspection, the practice clinicians checked all patient notes and updated the records with test results. We were sent evidence to demonstrate this had been completed and notes of a meeting held to discuss the issues and to put in place changes to practice policies to ensure the processes were embedded. 	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation except in relation to medicine reviews.

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) (01/10/2020 to 30/09/2021) (NHS Business Service Authority - NHSBSA)	0.60	0.71	0.71	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). (01/10/2020 to 30/09/2021) (NHSBSA)	10.8%	10.5%	9.8%	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 (01/04/2021 to 30/09/2021) (NHSBSA)	5.01	5.34	5.32	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	146.1‰	153.1‰	128.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2020 to 30/09/2021) (NHSBSA)	0.71	0.68	0.63	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	7.1‰	6.8‰	6.7‰	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.	Yes

Medicines management	Y/N/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.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	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 Area Team Controlled Drugs Accountable Officer.	N/A
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.	N/A
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 PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We saw evidence that following a patient discharge from hospital any changes in medicines contained in the discharge letter were reviewed and actioned by an appropriate clinician. • Prescription stationary was stored securely, and the practice had a process in place that was in line with NHS Counter Fraud guidelines. • Staff who were prescribers had regular meetings with the lead clinician where they reviewed the medicines they had prescribed and checked competencies. • Patients could request repeat medicine in person, online, over the phone or via the patient clinical system. • For this inspection we carried out a range of remote searches of the practice's clinical database. These included a review of the safe prescribing of a range of medicines. We found examples where patient records indicated tests had not been carried out in line with best practice. For example: <ul style="list-style-type: none"> - A search of patients on methotrexate, a high-risk medicine commonly used in the treatment of rheumatoid arthritis, identified that of 92 patients, two had not had the required monitoring. However, we reviewed the records of these patients and found the results had been checked on the hospital system and the prescriber had checked that monitoring was up to date prior to issuing the prescription. 	

Medicines management	Y/N/Partial
<p>- We found 88 patients were being prescribed spironolactone, a medicine to treat heart failure. We identified that four of these patients had not had the required monitoring. We discussed this with the practice, and we were told that some of these patients were historically non-compliant. Immediately following the inspection, the practice contacted these patients to arrange a further review.</p> <p>The practice took action to address the immediate concerns in relation to high risk medicines highlighted during the inspection. We were assured that policies and procedures had been amended to give another level of assurance in relation to a failsafe issue and this had been communicated to all staff. These new processes demonstrated how they would identify future issues, on an ongoing basis, as part of a quality assurance process.</p> <ul style="list-style-type: none"> • There was evidence that staff carried out the necessary checks of the medical oxygen, the defibrillator and the temperatures of the medicine fridge. • Patient Group Directions were authorised and signed by staff. • We found appropriate prescribing of antibiotics for children and patients with a urinary tract infection. 	

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:	104
Number of events that required action:	104
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> As part of the merger the practice had changed the significant events process and called them Learning Significant Events (LSEAs) which enabled all staff to become more engaged with the process. Staff we spoke with reported that the system worked well, they felt comfortable reporting any type of event or issue and the learning from these events was widely shared in team meetings. We saw that 104 incidents had been recorded and these ranged from clinical incidents to customer compliments and how well new process were working. A member of staff was assigned to manage the events and was able to show evidence of where trends had been identified and how they had been managed. The reporting back of the incidents was given as a whole picture and separated into teams for example, Admin, Practitioners and Management. 	

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

Event	Specific action taken
Referrals not progressed	A number of referrals had not been progressed in a timely manner. A new system and process was put in place with a tracker to check when referrals had been requested and that all stages of the process were checked weekly. Additional training was provided for staff and the changes were communicated in the staff meetings.
Medicine change not actioned	A patient's medication was stopped following an admission to secondary care. This was not actioned from the discharge summary. Once discovered the patient record was amended and the patient contacted. The policy was amended to ensure that medication changes on discharge summaries were sent to the prescriptions team to action.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial

Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had a system in place to monitor Medicines and Healthcare products Regulatory Agency (MHRA) and patient safety alerts but it was ineffective. When we searched the clinical system, we found that some alerts had not been fully actioned. • We found seven patients had been prescribed Amlodipine and more than 20mg Simvastatin together, contrary to a safety alert issued in 2014. We discussed the finding with the practice and they immediately ran the searches, made changes where appropriate and informed the patients of the change and reasons for this. We found three patients, aged over 65 years who had been prescribed a higher dose (over 40mg) of a medicine to treat low mood (Citalopram), despite a safety alert for this being issued in 2014. The practice searched the patient records and demonstrated that all three patients had been appropriately reviewed. • Immediately following the inspection the practice ran searches to check all alerts had been actioned and provided evidence to verify this and amended the current process to ensure that all alerts were acted upon in a timely manner and that a recheck process was undertaken every 4 months to ensure no patients had been missed. Both clinical and non-clinical staff had specific responsibilities for actioning and disseminating alerts. 	

Effective

Rating: Good

QOF requirements were modified by NHS England 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
Patients' treatment was regularly reviewed and updated.	
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">Records we reviewed showed care was provided in line with best practice guidance from National Institute for Health and Care Excellence (NICE), Medicines and Healthcare products Regulatory Agency (MHRA) and Clinical Knowledge Summaries (CKS).We reviewed patient records, including those relating to Do Not Attempt Cardiopulmonary Resuscitation (DN CPR), and found evidence that discussions about patients' needs, wishes and preferences were documented.The practice used a suite of clinical pathways which provided them with evidence-based resources for diagnosis, treatment and referrals.During the COVID 19 pandemic the practice worked closely with community teams to ensure that clinically vulnerable patients were supported, for example, domiciliary blood tests and anticipatory medicines were prescribed if appropriate.	

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age. The healthcare assistant (HCA) completed these assessments which included screening for diabetes. Initial tests were carried out in the practice and then the HCA would follow up on phone.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice had good links with the local hospice and the community matron who was part of the multidisciplinary team.
- 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 appropriate services.

Management of people with long term conditions

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with COPD were offered rescue packs. Nurses checked the patients notes and if the patient had experienced more than two exacerbations, they would be invited in for a face to face review.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Patients with asthma were offered an asthma management plan. During the COVID 19 pandemic patients were sent a text message through the clinical system (AccuRx) to ask them to check their

symptoms. The specialist nurse would then follow up on the results with a call to the patient to check if anything needed to be done.

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) (01/04/2019 to 31/03/2020) (NHS England)	94	102	92.2%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	112	120	93.3%	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) (01/04/2019 to 31/03/2020) (NHS England)	112	120	93.3%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	112	120	93.3%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	104	118	88.1%	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

- If a child did not attend an immunisation appointment it was noted in the patient record and the parents/guardians were sent a message to rebook. Special notes were added if the child who did not attend was on the vulnerable register.
- Unverified data provided by the practice, demonstrated the current percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) was now 91%.

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 30/06/2021) (Public Health England)	70.9%	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) (PHE)	68.7%	69.5%	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) (PHE)	66.0%	70.1%	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) (PHE)	55.4%	54.9%	55.4%	No statistical variation

Any additional evidence or comments
<p>Unverified data provided to us demonstrated the current uptake for women eligible for cervical cancer screening were screened was:</p> <ul style="list-style-type: none"> • 77% for women aged 25-49 • 80% for women aged 50-64. <p>The target for women aged 25-49 had improved but was still below the World Health Organisation (WHO) target of 80%.</p> <p>We spoke to the practice about the low uptake for the 25-49 age group and they told us it had been challenging through the COVID-19 pandemic. To address this the practice had a dedicated member of the admin team who contacted all patients who did not attend these appointments. Also they had recognised they had a high number of patients in this group who were from eastern Europe and were not attending screening appointments for a variety of reasons, so they were working with a local worker and interpreter to explain the importance of these appointments and to encourage attendance.</p>

Monitoring care and treatment

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

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

The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes
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Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

<p>The practice staff had worked hard to maintain patient services whilst supporting vulnerable patients during the COVID-19 pandemic.</p> <p>The practice carried out continual audit of minor surgery and we reviewed the results from before and after the COVID-19 pandemic from May 2018/19 to February 2021/22. The audits looked at different aspects of minor surgery:</p> <ul style="list-style-type: none"> • Procedures • Complications • Histology • Infection rates • Consent <p>The audit recorded that all relevant samples were sent off for histology and there was a process in place to notify patients of the results and any ongoing treatment. Consent for minor surgery was scanned and added to the patient record. This had been 100% up until the most recent cycle of the audit when three patients' consents were not recorded. This was investigated and it was found they were on the same day and it was an administrative error.</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.	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:

Following the practice merger, the management team had formed two clinical teams of GPs in order to maintain continuity of care wherever possible, and used an online triaging system so patients had better online access as well as the option to phone the practice to make an appointment or communicate with staff.

They had divided the Practice Manager role and had both Quality Assurance and Governance and Operational Managers.

- Staff reported good support for training, with protected time to complete their learning. New staff completed an induction and received mentoring support.
- All staff participated in annual appraisals and were supported to develop, for example by taking specialist leadership roles and promotions into new positions.
- Records of training and appraisals were maintained in individual staff files.
- All clinicians had an annual review and their competencies checked. Revalidation for nurses was supported within the team by the lead nurse and GPs.
- All nurses, paramedics pharmacists and physician associates discussed cases during mentoring sessions with the GPs and each other to develop their clinical skills and knowledge.
- If poor staff performance was identified this was managed by the practice manager or GPs. For example, new starters would have their progress checked at probationary reviews and if issues were identified they would be discussed and an improvement plan put in place. If no improvement was seen, an extended probationary period would be considered and further support and training were offered.

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-centered care when they moved between services.	Yes

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice offered support for patients and carers by providing links to health and wellbeing guidance on their website. There were also links to NHS advice about COVID-19, how to treat common conditions such as grazes and colds as well as links to NHS Live Well website pages. • During the COVID-19 pandemic staff continued to speak to patients about national health and wellbeing initiatives for example, stop smoking advice. Referrals continued to be made to the stop smoking service with calls and online appointments made to patients to provide support. 	

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: A review of patient records showed they were completed with good detail and included discussion relating to consent and mental capacity.	

Responsive

Rating: Good

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 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 minimise 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: <ul style="list-style-type: none">• The practice had an urgent care team who triaged each patient contact whether by telephone or electronic consultation. If classified as an urgent appointment the patient was added to the 'same day' list and allocated an appropriate appointment. This was face to face, or on the telephone and with a GP or other clinician.• Weekly ward rounds of the local care homes were carried out by video link. The acute visiting team would carry out face to face appointments with residents if deemed urgent and otherwise a practice nurse or GP would attend within a few days.• Information on accessing the service in various ways was on the practice website, on social media.	

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. 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: <ul style="list-style-type: none">The leadership team had supported the practice and its patients throughout the COVID-19 pandemic and had implemented the national guidance effectively by guiding staff appropriately and providing clear communication campaigns for patients.Succession planning was in place and the practice demonstrated this with a planned recruitment programme and reviewed the skill mix to best clinical cover. New starters had a comprehensive induction and training.Staff feedback was consistently positive about the leadership team.	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">A merger of two local practices had been completed in July 2021. The practice worked with external stakeholders to achieve this for example, the local clinical commissioning group (CCG) to agree working arrangements and patient lists and NHS Property Services (NHSPS) to agree buildings use. Staff had been fully involved in the discussions and arrangements to achieve this.Since the merger a different way of working had been put in place, two clinical teams with support staff assigned to each group of clinicians. Continued discussions were held with all staff to review the new ways of working.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Staff we spoke with told us that they felt that all members of the management team were approachable, and they could easily raise concerns if necessary. They also felt involved in decisions and the development of the practice. Staff we spoke with told us that the management team demonstrated that they were forward thinking and readily embraced change in the way that they had managed the merger and physical move of the practice. The significant event process had changed to encourage more staff to be involved. They had renamed the process Learning Significant Events. More events were reported, and staff were involved in reviewing each incident and putting in place and following up on actions identified. Face to face resilience training had been undertaken for admin staff. this was to help manage conflict and support health and wellbeing of staff. The management team had also planned an away day to be held later in the year. The practice used an external provider for HR support and they also provided an employee assist programme. The practice staff had access to the CCG freedom to Speak up Guardian as well as practice specific individuals, who were nominated, and information was on posters in staff areas. 	

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

Source	Feedback
Staff	<p>We were told by staff that this was an excellent place to work, all of the GPs and managers were approachable, accommodating and very committed to patients and providing excellent care.</p> <p>They felt supported by the whole team at all levels, education was high on the agenda and staff were encouraged to develop.</p> <p>All staff had worked well together through the merger.</p> <p>More clinical support was available than ever before.</p>

	There was a very positive atmosphere, very supportive, the staff all had goals for future.
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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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Since the merger there was a new structure in place which included a Governance Manager. Meetings were held regularly, and new systems were discussed and implemented. For example, the new significant event process which also encouraged staff to develop an operating procedure to address the issues identified and was seen as a very supportive process by staff. 	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance, however the monitoring of safety alerts was not always effective.

	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:	
<ul style="list-style-type: none"> The practice had introduced new training to review competencies. This enabled managers to identify any areas for improvement before it became an issue. The practice did not always review and action safety alerts, We raised this with the practice and immediately following the inspection searches were completed and appropriate action taken for all patients affected by an alert. We were sent documentary evidence to corroborate this. 	

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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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> For patients who may have difficulty in accessing the electronic consulting application, the reception staff could complete a shorter version whilst on the telephone to patients. This would then be passed to the triage team. Staff who needed to work from home due to shielding or isolating were provided with the necessary equipment and managers had regular telephone contact with them to support them in lone working. Staff we spoke with verified this. The practice telephone system allowed remote access so therefore no reduction in the system was experienced when staff had to work from home. This process had been separately risk assessed to ensure confidentiality The practice had use of a room, with an external door for donning and doffing personal protective equipment (PPE) to enable them to see patients who were or may be Covid 19 positive. 	

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
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Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The Patient Participation Group (PPG) had regrouped following the merger and the impact of the COVID 19 pandemic. Meetings were minuted and included the following: a record of all discussions, questions for the practice, updates on the merger, and the new clinical system for appointments. The practice worked with the local network, a local organisation looking at; the social prescribing contract, outreach workers for the local homeless shelter to provide nurses to help with the COVID 19 vaccination programme. 	

- They had engaged with local councillors to discuss merger.
- The practice had worked with a local interpreter to engage with local workers who needed interpreter services to encourage them to attend reviews, smear tests and vaccination appointments.
- The practice had access to a young person's social prescriber, who helped to signpost young patients to access service specific to them, for example, young people's mental health advisors.
- We saw the practice used its notice boards and the website to communicate with 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.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had arranged some 'Green' training for a salaried GPs to address green/sustainability agenda. This looked at areas such as, looking at electric cars for visits. • Learning was shared in a variety of meetings and notes were available to those unable to attend. • Staff we spoke with told us that the partners encouraged new ways of working especially throughout the COVID 19 pandemic. • Staff were able to access secondary care clinicians by telephone for advice and guidance to help reduce the need for hospital appointments. • Staff reported on a culture that was open, supportive and caring. They said they would raise issues if they had concerns and felt their concerns would be listened to. We were also told the provider encouraged a listening culture where new ideas were invited and considered. • We were also told the culture was welcoming, friendly and caring and staff had been supported well during the COVID-19 pandemic. 	

Examples of continuous learning and improvement

The practice was part of a local research group. This was part of a group of seven other practices across the Southwest of England. They had undertaken multiple clinical trials for large pharmaceutical sponsors.

The most recent studies included an immunisation trial for the introduction of Meningitis ACWY into the infant schedule for which the practice recruited 24 patients from the local population.

During the Covid-19 pandemic the practice took part in a study monitoring efficacy and safety of an antibody for Covid-19 recruiting 32 volunteers from the practice population. At the time of inspection, the practice was involved in seven active trials.

The practice research team included GPs, specialist nurses and support from the other nursing and health care assistants when required. The practice told us that the research provided an opportunity for patients to access medication and treatment at the forefront of medical care. The clinicians'

involvement in research helped develop relationships between the research practices and strengthen local ties and cooperative working.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a 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.
- PHE:** Public Health England.
- 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.
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- ‰ = per thousand.