

Care Quality Commission

Inspection Evidence Table

Woodside Surgery (1-541134350)

Inspection date: 30, 31 March 2022

Date of data download: 20 March 2022

Overall rating: Requires Improvement

The provider has received an overall rating of requires improvement as safe systems and processes were not sufficiently well established, clinical effectiveness was not demonstrated, and governance processes were not fully established.

Safe

Rating: Inadequate

We rated the provider as inadequate for safe, as systems for taking action in relation to Medicines and Healthcare Regulatory Agency alerts were not sufficiently established. In addition, the processes for management of high risk medicines were not effectively implemented. Patient records were not always appropriately coded to indicate the presence of medical conditions, and infection prevention and control measures were not effectively implemented.

Safety systems and processes

There were gaps in practice 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

Safeguarding	Y/N/Partial
Explanation of any answers and additional evidence:	
<p>There were some gaps in relation to evidence of uptake of safeguarding training. One member of the clinical team had not received adult safeguarding training and was out of date for child safeguarding training update. Uptake of safeguarding training for locum staff was not recorded on the staff overview records. The provider told us they checked individual's training record upon deployment to the service from the locum agency.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
Explanation of any answers and additional evidence:	
<p>The practice made use of a locum agency who carried out all necessary pre-employment checks on behalf of the practice. The practice sought to obtain evidence of training undertaken by locums and held this information in the practice.</p> <p>At the time of our visit the practice was reviewing their approach to staff vaccinations in line with Public Health England guidelines. They required staff to provide evidence of their vaccination status, including COVID-19 vaccination.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes
Date of last assessment:	March 2022
There was a fire procedure.	Yes
Date of fire risk assessment:	March 2022
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence:	
<p>The fire risk assessment required the store room to be cleared of excess equipment. In addition, use of heaters were to be used only with the approval of the manager.</p> <p>The provider was unable to provide evidence that all staff had completed fire safety training within the last 12 months.</p> <p>Fire wardens had been appointed for each site. A health and safety lead was identified within the practice.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not 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:	Yes 1 July 2021
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: Not all staff had up to date IPC training at the time of our visit. An IPC audit had identified actions which had not been completed. Following our site visit the practice acted quickly to remove excess clutter from one clinical room and undertook to review cleaning processes for carpeted areas.	

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.	No
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
A number of staff had not completed basic life support training within the previous 12 months. The provider told us an in-house training session had been arranged within four weeks of our visit. The main surgery and both branch sites had emergency medicines and oxygen available. We saw that medicine to treat suspected meningitis was not included, nor was medicine to treat epileptic seizures. Following our inspection, the provider undertook to review their stock supply and complete risk assessments to explain their rationale for any emergency medicines not held.	

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.	No
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
Explanation of any answers and additional evidence: All test results were returned to the clinician who requested them. The provider told us that in the event of the absence of that member of staff another clinician would review them and address any issues. There was no documented process for this, in the form of a formal rota or 'buddy system' to ensure this occurred in all cases.	

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) (01/10/2020 to 30/09/2021) (NHS Business Service Authority - NHSBSA)	0.97	0.83	0.71	Tending towards variation (negative)
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)	8.4%	6.7%	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)	4.66	4.83	5.32	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	241.0‰	164.3‰	128.1‰	Tending towards variation (negative)
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)	1.02	0.57	0.63	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	13.0‰	7.7‰	6.7‰	Variation (negative)

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.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	No
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	No
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.	No
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.	No
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.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	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.	Partial
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the time of our visit there were no processes in place to record and track blank prescriptions in the practice. The provider told us most prescriptions were generated automatically to the relevant pharmacy. Following our feedback, a protocol for tracking prescription serial numbers being placed in printers was developed and shared with us.</p> <p>There were no formal processes in place for the oversight and auditing of non-medical prescribing patterns.</p> <p>The processes for reviewing high-risk medicines were insufficiently thorough, and patients had not had the necessary reviews and investigations carried out. For example, Five patients (of 16) prescribed spironolactone plus ACE/ARB inhibitors were overdue for review. Of the five, two patients were also under the care of cardiology who was carrying out the required monitoring. Of the remaining three, blood tests ranged from 9 December 2019 to 21 May 2021. The most overdue one was a 79 year old patient with a last result showing high potassium who had not been reviewed since 2017.</p>	

Medicines management

Y/N/Partial

Following our feedback, the practice provided evidence within two working days that all relevant patients had been reviewed, and appropriate follow-up scheduled.

We saw that antimicrobial, nerve pain medicines and psychotropic medicines prescribing was higher than average in some cases. We did not see any evidence that plans were in place to monitor and/or optimise prescribing patterns for this range of medicines.

We saw that emergency medicines were in place at all three sites where patients were seen. Some medicines, for example benylpenicillin for suspected meningitis, and diazepam for epileptic seizure, were not stored. Risk assessments to provide a rationale for the lack of storing these medicines had not been carried out. Appropriate processes for monitoring stock levels and checking expiry date were in place.

Vaccine refrigerators were checked and temperatures were recorded daily. We saw that refrigerators in branch sites were only checked on the days when the site was in use. We did not see any evidence that temperatures had gone out of range at any time. Minimum and maximum temperatures were recorded, and the use of data loggers enabled staff to track temperatures in the intervening period. Following our feedback, the practice undertook to ensure that daily checks were carried out on all refrigerators.

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:	3
Number of events that required action:	2

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

Event	Specific action taken
Blood test carried out on wrong patient where the name and address were the same.	Learning from the event: discussed at staff meeting. Staff reminded to ensure that patients' date of birth in addition to name and address were checked before any intervention.
Blood samples not brought out of clinical room in time for collection	Four patients were recalled and their blood tests repeated. Reminder to all staff to ensure samples were removed from clinical rooms at the end of every session.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	No
Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence:	
<p>The system for taking action on Medicines and Healthcare products Regulatory Agency (MHRA) alerts was ineffective. Some patients had not been appropriately assessed and the necessary adjustments to their prescribed medicines been made. For example; an alert relating to patients taking simvastatin 40mg plus amlodipine. We reviewed five patients, and found that, all were still prescribed this drug combination. One recent medication review by a pharmacist had not picked this up. In another case, a pharmacist had doubled the dose of amlodipine being prescribed.</p> <p>We reviewed action taken following an MHRA alert relating to patients over 65 years prescribed citalopram 40mg. We looked at five patients records and found that all were still on a repeat prescription of citalopram 40mg. Three of these patients had not had a medicines review in the previous 18 months; the remaining two had review codes added by practice nurses who had failed to pick up the issue relating to citalopram prescription.</p>	

Systems for coding of patients were not effectively established. We reviewed five patient records, and found that none had not been appropriately coded as diabetic or pre-diabetic following abnormal test results.

Effective

Rating: Requires improvement

We rated the provider as requires improvement for effective because quality improvement activity within the service was limited in scope. In addition, processes for maintaining oversight of staff training updates were not sufficiently well established.

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 mainly assessed, and care and treatment was mainly 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.	Partial
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.	Partial

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
<p>Explanation of any answers and additional evidence:</p> <p>We saw that clinical updates were a standing agenda item on clinical meetings. However, we identified gaps in relation to the implementation and maintenance of recommended changes to practice; for example in relation to Medicines and Healthcare Regulatory Agency (MHRA) alerts. We also identified gaps in relation to processes for carrying out routine reviews on patient care.</p> <p>Staff had access to clinical pathways and tools as part of their clinical record system.</p>	

Effective care for the practice population

Findings

- The practice had use of a clinical tool which provided a framework for identifying and holistically assessing the needs of older patients living with moderate or severe frailty.
- Practice nurses reviewed the medicines needs specific to the long-term condition being reviewed. We saw that processes for completion of reviews by an appropriate clinician of other medicines being prescribed were not fully established.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients.
- The practice notified eligible patients of their eligibility to have the meningitis vaccine, for example before attending university for the first time.
- NHS health checks of patients aged 40 to 74 had been recently reintroduced at the time of our visit.
- One of the practice nurses took a lead role in carrying out annual health checks for patients with a learning disability. We saw that all had been offered a check in the previous 12 months.
- There were processes in place to coordinate care for those patients approaching the end of life.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- Appropriate alerts on patient records were put in place when it was identified that substance misuse was an issue.
- 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

- Processes for monitoring of long-term conditions were in place. Our record searches showed some delays in relation to management of results for patients with long-term conditions such as diabetes, asthma, chronic kidney disease and hypothyroidism. Following our feedback the practice provided evidence within two working days that highlighted patients had been reviewed and follow-up arranged, with plans in place to ensure regular searches maintained an overview of outstanding or overdue tests or reviews.
- Patients with long-term conditions were recalled as part of a 'one stop shop' for review of their conditions at one appointment. Some delays or interruptions had occurred due to events outside the control of the practice, for example, lack of access to blood collection bottle samples
- Staff were able to access essential professional updates to enable them to effectively carry out long-term condition reviews. The provider had plans in place to develop a systematic approach to identifying and scheduling relevant training for the appropriate staff.
- Summary care records and shared clinical systems enabled clear and accurate information to be shared with relevant professionals when deciding care delivery for patients with long-term conditions.
- There were gaps in systems to identify pre-diabetic and diabetic patients. At the time of our inspection we found that appropriate coding was not always in place. Following our feedback, the practice provided evidence within two working days that all identified patients had been reviewed and appropriate coding and follow-up arranged.
- 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 in the event of an acute exacerbation.
- Asthma management plans were developed in consultation with patients as part of routine asthma reviews.

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)	104	114	91.2%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received	98	117	83.8%	Below 90% minimum

Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)				
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)	98	117	83.8%	Below 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)	99	117	84.6%	Below 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	114	91.2%	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>

Any additional evidence or comments
The practice liaised with local health visiting teams to follow up with families where parents or carers failed to bring babies and children for vaccination. A system of telephoning families the day before their scheduled appointment had been introduced to reduce the number of children failing to be brought to the appointment. At the time of our visit it was too early to assess whether or not this was having a positive impact.

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)	67.7%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	65.2%	67.0%	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)	63.2%	67.9%	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)	53.8%	57.0%	55.4%	No statistical variation

Any additional evidence or comments

The practice provided evidence from their records which indicated that 77.4% of patients aged 25-49 years had received a cervical screen in the appropriate timescale; and that 81.6% of patients aged 60 to 64 had received their screening. This related to the period from 1 April 2021 until 31 March 2022. This was unverified data

There were plans in place to develop a screening team from within the practice staff to promote cancer screening of all types, and maintain active management of promoting cancer screening.

Monitoring care and treatment

Some quality improvement activity was carried out within the practice.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Partial
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 not initiated any internal quality improvement activity in recent months. However, they participated in Primary Care Network (PCN) initiatives. For example a review was undertaken in relation to the two week wait protocol for patients with lower gastro-intestinal symptoms. This checked the number of patients being referred and ensured that the correct proforma was in use. A similar review was undertaken in relation to the two week wait protocol for gynaecology referrals. In addition, processes for responding to e-consult enquiries were improved, where a clinician texted the patient to establish a convenient time for the practice to call the patient to discuss the issues further. A missed call proforma had been developed to formalise the capture of relevant information.

Effective staffing

The practice was able in the main 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.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>There were no formal systems in place for clinical supervision of staff. Informal mentoring was available to advanced practitioners, either routinely scheduled or when required upon request. Staff told us they felt able to access additional support and guidance when needed. Support for revalidation purposes was offered, and appraisals, although not all completed at the time of our visit, were timetabled to be completed for all staff within four weeks of our visit.</p>	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>As part of our inspection we looked in further detail at how the practice worked with partner agencies and other care providers in coordinating care for patients outside normal working hours. We found that appropriate information sharing and recording systems were in place to optimise care for patients.</p>	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Recent national initiatives in relation to health improvement promotional events had been paused due to the COVID-19 pandemic.</p> <p>Staff made use of consultations to opportunistically discuss health choices, provide supporting information and signpost to relevant services.</p>	

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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed three patient records where DNACPR orders were in place. Whilst we found that there was evidence of patient discussion, agreement of reasons for the decision and confirmation whether or not the patient had capacity to consent to DNACPR, we found that systems for regular review of this decision were not in place. In some cases the order had been in place for a number of years without any evidence of a review or a planned review. Following our feedback, the practice provided evidence that the identified patient had been contacted, and after discussion the decision was made that a DNACPR order was not appropriate in her case.</p>	

RESPONSIVE

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: All three sites operated by the practice offered access to telephone, face to face or online appointments. E-consult provided an additional resource which aimed at reducing pressure on the telephone system and had proved useful for patients with hearing impairment. Staff had access to telephone interpreter services. Information could be provided in large print for patients with visual limitations. Extended access appointments were offered via the PCN at a local surgery. Out of hours care was available via NHS111 or Local Care Direct.	

Well-led

Rating: Requires Improvement

We rated the provider as requires improvement for well-led as systems for oversight and governance of clinical and operational processes were not implemented.

Leadership capacity and capability

The leadership team strove to be compassionate, inclusive and effective.

	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 partners demonstrated a commitment to developing and improving the service after a period of upheaval in relation to a number of staff changes. A deputy practice manager was being appointed to allow for delegation of some practice manager duties.	

Vision and strategy

The practice had a vision and 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: Regular clinical and staff meetings were held where current and upcoming issues in the practice were discussed. Staff told us they felt involved in the development of the service and understood their role within this. A staff bulletin and secure staff social media group enabled updates and information to be shared in an appropriate forum.	

Culture

The practice had a culture which sought to support 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
Explanation of any answers and additional evidence: We heard of examples where staff had been supported through difficult periods in their personal lives. We saw evidence which showed that the practice responded in an open and transparent way when patients were impacted by an error on the part of practice staff.	

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

Source	Feedback
Staff member	I feel supported and there is always someone to help when needed.
Staff member	Lovely work environment.

Governance arrangements

There were gaps in relation to 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.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: We identified gaps in relation to oversight of medicines management, infection prevention and control and clinical leadership roles. We were told that that 'task groups' had been created on the clinical system to enable staff to forward, for example any queries or issues in relation to safeguarding queries. However we found there were no formal processes for clinical supervision in relation to non-medical prescribers. There was no written protocol for the management of test results. This meant that when staff were not	

in work results were picked up in an 'ad hoc' way by clinicians who were working on the day. This meant that there was the possibility of urgent abnormal test results being overlooked.

Processes for taking action on MHRA alerts were not sufficiently embedded, and reviews for patients taking high risk medicines were not always completed within recommended timescales.

Oversight of uptake of staff training and appraisal activity was not effectively maintained. There were gaps in relation to uptake of key training for staff in some cases. Appraisals were overdue at the time of our visit. We were told these had been scheduled in for completion within the next few weeks.

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Partial
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.	Partial
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We identified clinical risks in relation to the management of patients with long-term conditions and those taking regular medicines. In addition, infection prevention and control measures were not implemented effectively. Following our feedback, the practice responded promptly to review their processes in relation to medicine management and infection control.</p> <p>Operational risks were identified as oversight of staff training was not sufficiently thorough.</p> <p>A business continuity plan was in place which contained guidance in managing major incidents. Staff were aware of it's contents.</p> <p>At the time of our visit a large number of staff had not completed basic life support training. This was scheduled to be completed within the next few weeks following our visit.</p>	

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.	Partial
Staff were supported to work remotely where applicable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We saw that infection prevention and control measures had been updated and implemented to reflect COVID-19 guidelines; however, we also found that one of the clinical rooms was cluttered at the time of our visit, and that carpeting in the waiting area of one branch site was stained.</p> <p>There were no formal processes in place to monitor and manage issues relating to access to appointments. However, we learned that the leadership team were aware of busier periods and made adjustments to staff cover in line with this.</p> <p>We saw that a number of options were available to patients, in the form of telephone, face to face or online appointments.</p>	

Appropriate and accurate information

The practice reviewed data and information to 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.	Partial
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>A data quality officer had recently been appointed, whose role it was to maintain oversight of practice performance data. The practice were aware of areas where review was needed, for example in relation to prescribing patterns and uptake of childhood immunisation and cervical cytology. Plans were being developed to improve their performance in these areas.</p>	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes

The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	N/A
The practice advised patients on how to protect their online information.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Measures were in place to protect patient privacy and dignity. For example, they would not be asked to submit photographs of any intimate area for review by a clinician. Instead, face to face consultations were arranged. Any photographs submitted were scanned into patient records as an attachment.</p>	

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 made efforts to engage with the group and had begun sharing internal updates such as staff changes with them. They encouraged the PPG to make suggestions for improving the patient experience.

Continuous improvement and innovation

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

	Y/N/Partial
There was a focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: Significant events, near misses, complaints and compliments were included as a standing agenda item on clinical meetings. We heard of examples which showed that changes were made in response to issues and staff were kept informed.	

Examples of continuous learning and improvement

The practice team was relatively recently established. The leadership team saw connection and engagement with patients as a priority. Staff wellbeing was described as of high importance. The practice responded positively to feedback received from CQC following our inspection, and submitted evidence that improvements were immediately implemented.

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.