

Care Quality Commission

Inspection Evidence Table

Willesborough Health Centre (1-557603398)

Inspection date: 08 December 2022 and 19 December 2022

Date of data download: 29 November 2022

Overall rating: Good

At our previous inspection carried out in November and December 2021 Willesborough Health Centre was rated Requires Improvement overall. This was because:

- The provider had not ensured that systems and processes were established and operating effectively to ensure care and treatment was provided in a safe way to patients.

At this inspection we found that these issues had been resolved and we have rated the practice Good overall.

Safe

Rating: Good

At the last inspection in November and December 2021 we rated the practice as Requires Improvement for providing **safe** services because:

- Staff had been appointed to roles without demonstrating they had the skills, knowledge or experience to perform their duties.
- Incomplete records of staff vaccinations and risks to staff were not identified, assessed and mitigated.
- There were unresolved fire and health and safety risks at branch surgeries (including management of clinical waste).
- There were incomplete infection control processes and no annual infection prevention control statement.
- Staff had failed to complete inductions prior to independent working.

At this inspection in December 2022, we found that those issues had been satisfactorily resolved. The practice is therefore now rated Good for providing **safe** services.

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.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider had 2 designated safeguarding leads and an administration lead. All staff we spoke with knew how to identify and report concerns. There were policies and referral pathways which were accessible to all staff. The policies outlined who to contact for further guidance and how to contact them. We also saw minutes of monthly meetings between the 3 leads when the registers were reviewed, and safeguarding concerns considered. Concerns were shared where appropriate at the primary care network (PCN) multi-disciplinary team (MDT) meetings. There was a dedicated email address used exclusively for safeguarding issues. Staff demonstrated they understood their responsibilities and were trained to an appropriate level for their role.</p> <p>The computer system flagged up an alert if a child was at risk and flagged and cross-referenced members of the household or close family.</p> <p>We reviewed the training records of 10 members of staff, and all were up to date with safeguarding training appropriate to their role.</p> <p>We saw there was a chaperone policy, there were several members of staff at each site who were trained as chaperones and posters throughout all three buildings advising patients that they could request a chaperone. We saw that staff who were chaperone trained had had appropriate DBS checks carried out.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff files were all held centrally. We looked at 10 staff files for staff who worked across a range of roles across the three sites we inspected.</p> <p>All files contained: proof of identification, two references, an application form or CV, Disclosure and Barring Service (DBS) checks, interview notes (for those post regulation), health check questionnaires, immunisation status, signed contracts, confidentiality policy and agreement, job descriptions, appraisals and staff training records.</p>	

The practice maintained records of up to date information relating to staff indemnity insurance and proof of registration with professional bodies. For example, the General Medical Council and the Nursing and Midwifery Council.

For new starters evidence of induction was seen. This was a 12-week programme which could be extended or shortened as necessary.

Safety systems and records	Y/N/Partial
<p>Health and safety risk assessments had been carried out and appropriate actions taken.</p> <p>Date of last assessment: Willesborough and St Stephens Health Centres 26/06/2022 Singleton Health Centre 28/06/2022</p>	Y
<p>There was a fire procedure.</p>	Y
<p>Date of fire risk assessment: Willesborough Health Centre 31/10/2022 St Stephens Health Centre 14/10/2022 and November 2022 Singleton Health Centre 14/10/2022</p> <p>Actions from fire risk assessment were identified and completed.</p>	P
<p>Explanation of any answers and additional evidence:</p> <p>The buildings at Willesborough Health Centre and Singleton Health Centre were owned by the providers. The building at St Stephens Health Centre was owned by a third party and managed by NHS property services.</p> <p>At our previous inspection of November and December 2021, we found that there were unresolved fire and health and safety risks at the branch surgeries (including management of clinical waste). At this inspection we found that these issues had been resolved at Singleton Health Centre, and there were no outstanding health and safety risk assessment actions at St Stephens Health Centre. However, the practice was trying to resolve issues with their landlord over two conflicting recent fire risk assessments.</p> <p>We identified a potential trip hazard from some carpet tiles at St Stephens Health Centre but saw that it had been recently reported to the management company. Following our inspection, the practice sent us documentary evidence to show that a trip hazard sign had been ordered to place over the area.</p> <p>There were no issues related to the fire risk assessments found at Willesborough or Singleton Health Centres. However, at St Stephens Health Centre we found recent fire assessments that had been commissioned by the landlord but not been remedied. We found the provider had asked the landlord to action this but this had not been done at the time of our inspection.</p> <p>We saw minutes of a recent managers' meeting where these issues were discussed, and actions agreed; as well as actions that would be taken should the work not be carried out by the landlord. We also saw that a minuted fire wardens meeting was held with a plan for regular 6 monthly meetings.</p> <p>In view of this, the practice had carried out a risk assessment and actions to mitigate against the possible increased fire risk. They had undertaken to:</p>	

- Identify and train an additional two fire wardens;
- Undertake bi-monthly (every two months) fire evacuation drills at the premises, in addition to any scheduled fire alarm testing;
- Ensure all staff were up to date with their mandatory fire safety training and had them repeat this on a six monthly, rather than annual, basis.

Fire evacuation plans were displayed in staff communal areas throughout the practices.

Site managers at each site scheduled fire drills bi-monthly. Fire drill records were stored on the practices shared system. We saw that a fire drill had been carried out 2 weeks prior to the inspection at Willesborough.

Fire alarm system testing was completed weekly by the site managers, each site had a red book for recording fire alarm results. We saw no issues had been identified at any of the 3 sites.

Fire extinguishers had been checked at all 3 sites within the previous 12 months.

The practice had eight staff trained as fire marshals however, they were increasing the number across the 3 sites. We saw copies of their training certificates. They were also moving to 6 monthly training as opposed to the original annual training. All fire risk assessments and recording of fire alarm testing was kept on the internal internet with each site manager being responsible for keeping the information up to date. The General Manager oversaw this via alerts.

We saw records that showed that Portable Appliance Testing (PAT) and calibration of medical equipment had been carried out across all 3 sites within the last 12 months.

We saw Legionella (a bacterium found in water supplies which can cause severe respiratory illness) risk assessments; testing and routine systems and processes for monitoring of this were being maintained for all 3 sites. Water temperature readings were regularly recorded by a third party. On 6 December 2022 the practice were told that the water temperatures at St Stephens Health Centre, were found to be outside the accepted range for cold water (less than 20 degrees Celsius) and hot water (more than 50 degrees Celsius). We saw that the landlord was informed via email and we saw a response advising that an engineer would be arranged to carry out a review. They had not been sent a date and had been following it up. They had carried out a risk review of the situation and had an action plan to commission their own engineer if they did not get a response within a stated timeline.

During the on-site inspection of St Stephens Health Centre, it was noted that although there was a key code lock to the kitchen available, this was not being used on the day of the inspection. There was the potential for patients and visitors to access the kitchen when it was unattended. There was a wall mounted boiler that dispensed hot water for staff to make drinks and this was a potential risk to patients. We raised this with the practice and we saw they had circulated an email to all staff who used St Stephens Health Centre which reminded them of the key code and advised that the kitchen door should be closed at all times. There were also warning signs on the hot water boiler and a 'kitchen - staff only' sign on the door.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. External company audits completed September 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<p>The practice maintained appropriate standards of cleanliness and hygiene. We observed all 3 premises to be visibly clean and tidy. We looked at the training records of 10 staff members and saw that they received appropriate training in infection prevention and control (IPC).</p> <p>There was a clinical lead for IPC who had received additional training to carry out the role. They were assisted by a deputy lead practice nurse. The practice also employed an external contactor who provided practice cleaners with training in NHS cleaning standards.</p> <p>We saw that there was an annual IPC statement dated 17/12/2021 and revised 12/01/2022. This was also available on the Ashford Medical Partnership website.</p> <p>We saw the latest IPC policy was dated 23/1/2022 and covered all 3 sites. It was comprehensive and accessible to all staff on a software system accessible to all staff.</p> <p>An annual audit was completed by the external contractor on 01 and 02 September 2022, with action plans produced for each of the 3 sites. We saw that all actions had been completed by the date of the inspection; with the exception of the recommendation to change the types of taps, overflows and plugs which were to be addressed at the next refurbishment of the premises.</p> <p>Additionally, we saw that visual checks were completed monthly for all 3 sites and recorded. Comprehensive guidance notices were available for all 3 sites in relation to schedules of cleaning of rooms and a hand washing audit was carried out on 20/10/2022. There were no issues identified.</p> <p>Clinical waste and clinical specimens were managed and stored appropriately at all 3 sites.</p>	

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y

Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	P
Explanation of any answers and additional evidence:	
<p>There was a comprehensive induction system for all new staff including temporary staff, appropriate to their roles and tailored to their experience in the role. Staff that we talked with confirmed that they had received a thorough and appropriate induction.</p> <p>We looked at the training records of 10 members of staff and found that all these staff members had completed basic life support training and the recognition and management of patients with potential sepsis appropriate to their role.</p> <p>We saw that administrative staff rotas were prepared by practice managers at each site and administrative staff worked and covered one another at a single site. If necessary, where a member of staff was not available, the site manager would cover. Clinical staff worked across all 3 sites and a single rota was prepared for this. GPs had buddies who covered their administration whilst they were away (for example, test results and documents).</p> <p>The practice had been trying to recruit both clinicians and administrative staff so that they could provide access for patients at a level that could satisfy the demand. The provider told us this had been difficult and that they had run an advert for new GPs twice, each time for 6 months without receiving any applications. They had however, now appointed 2 long term locum GPs and 2 GPs they had trained had returned as permanent salaried GPs. They had also appointed non-medical clinicians and further administration staff. The provider told us they were still advertising for new staff.</p> <p>The practice had only just started employing GP locums over the last month and were in the process of producing a locum pack. We were told by locums that they had to provide all of the documents to the practice. A GP partner had given them a personal induction and discussion of their role and expectations and was available to answer any queries. Locums we spoke with told us that all staff were friendly and helpful if they had any queries; they were aware where the policies and protocols were stored on the intranet and had access to them; and they were made aware of procedures such as referral processes and the management of test results.</p>	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. ¹	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y

There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence:	
Review of patient records identified that care records were managed in line with current guidance.	
The practice had a summarising team. When records were received at the practice the notes were summarised in chronological order ensuring the electronic record matched the paper record. New patients were also referred to the medicines management team for a review of their medications.	
We saw that the practice had a reliable system for referrals including two week wait referrals for potential cancer diagnoses. We saw that there were built in safeguards to ensure that patients received timely appointments. There was a potential to add a further layer of assurance that patients had received a timely appointment under the two-week wait protocol which we shared with the provider. The practice immediately implemented the suggestion.	
We saw that there were effective systems for the safe management of test results and the workflow of documents through the practice. There was now a specific workflow team who ensured that documents were scanned and coded correctly and were passed to the appropriate clinician who then tasked the appropriate staff with any further actions. The workflow team ran regular reports which identified if documents had not been actioned. Any uncompleted tasks were referred to the clinical lead. The computer system alerted the management when clinicians were on leave. All clinical staff had a "buddy" so they could see what was in their inbox when they are away and action it. We did not identify any backlogs of unprocessed test results or documents.	
GPs alerted the coding team if there was an issue with any coding. Staff told us that the GPs were supportive and responsive to requests for advice.	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHS Business Service Authority - NHSBSA)	0.83	0.85	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total	7.3%	8.6%	8.5%	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2021 to 30/09/2022) <small>(NHSBSA)</small>				
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 (01/04/2022 to 30/09/2022) <small>(NHSBSA)</small>	6.45	5.75	5.28	Tending towards variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	104.7‰	132.5‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) <small>(NHSBSA)</small>	0.43	0.60	0.58	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) <small>(NHSBSA)</small>	7.0‰	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.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. ¹	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. ²	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y

Medicines management	Y/N/Partial
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.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p data-bbox="57 813 1273 846">Explanation of any answers and additional evidence, including from clinical searches.</p> <p data-bbox="57 891 1543 958">The practice medicines management team had introduced a trends and analysis review to improve practice processes. Learning was shared monthly via a newsletter to all staff members.</p> <p data-bbox="57 1003 1543 1115">The Integrated Care Board (ICB) prescribing data was analysed regularly and all prescribers were informed. If there were outliers, these were discussed with the individuals. We were also told about this by staff members who found it an extremely useful practice.</p> <p data-bbox="57 1160 1543 1272">We saw there was an inventory of emergency medicines held at each site and regular monitoring took place. The provider held medical oxygen and a defibrillator at all 3 sites, we saw evidence of regular monitoring of these.</p> <p data-bbox="57 1317 1543 1384">We looked at a selection of Patient Group Directions (PGDs) and Patient Specific Directions (PSDs) and found that these had been completed correctly.</p> <p data-bbox="57 1429 1543 1541">We saw there was an inventory of emergency equipment at all 3 sites and regular monitoring took place. Appropriate emergency medicines were held at each site, all were regularly monitored to ensure their presence, and all were in date.</p> <p data-bbox="57 1585 1543 1697">The practice told us that they had been auditing the use of opiates and similar medicines and that they had had recognition for this from the ICB. The ICB confirmed that they reviewed the data which appeared to confirm that there has been a reduction in high dose opiate items by the practice.</p> <p data-bbox="57 1742 1543 1877">We saw that an audit of patients taking a drug called colchicine (a medicine used in the treatment of gout) had been completed to ensure patients were not over prescribed following a serious incident elsewhere and implemented by the Integrated Care Board (ICB) across Kent and Medway. Sixteen patients were identified and called in for review with the clinical pharmacist.</p> <p data-bbox="57 1921 1543 2033">We completed a series of searches on the practice's clinical records system. These searches were completed with the consent of the provider, and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance.</p>	

- We looked at the records of patients who had been prescribed methotrexate, a medicine used to treat rheumatoid arthritis and other related conditions. Our search revealed 84 patients who had been prescribed this medicine. We looked at records of 5 of the 10 patients who potentially had not had the correct monitoring. All 5 were being managed in line with current guidance. Each of these 5 patients were being monitored under secondary (hospital) care. There was evidence in the records that the prescriber had checked that the monitoring was up to date prior to issuing a prescription in 4 out of 5 patients. The fifth patient was managed entirely within secondary care.
- We looked at patients on amiodarone a medicine used to treat or prevent heart rhythm disorders. Our searches identified 22 patients were prescribed the medicine, 9 of which potentially had not had the required monitoring. We reviewed 5 records, 3 had already been recalled and 2 were just at the point of needing a recall. All 5 were therefore being managed in line with current guidance. The practice had a system whereby the length of time between prescriptions would be rapidly reduced should a patient on a high-risk medicine repeatedly fail to present for monitoring.
- We also looked at patients on DOACs (Direct Oral Anti-coagulants- a class of medicines that help to prevent blood clots forming in arteries, veins and the heart). Our search identified 556 patients who had been prescribed these medicines, 63 of which had potentially not had the required monitoring. We reviewed 5 patient records and found that 3 were monitored appropriately. We saw 1 patient had stopped taking the medicine and the practice had contacted them for a review prior to our inspection. We also saw 1 patient was overdue for monitoring tests but saw the provider had contacted the patient several times to invite them for an appointment
- We saw that 166 patients on benzodiazepines and z drugs (drugs generally given short term to help manage poor sleep, and in the past used to manage anxiety, but which had potential to cause dependency) were due for a review. Of the patients on gabapentinoids, 23 had not had a review in the last year. The practice told us they had an ongoing system to review all their patients on DFM (dependant forming medications) which included benzodiazepines, opioids, Z drugs and gabapentinoids. Although they had a system which they were using to identify patients on z drugs that were due for reviews they told us they would implement another system similar to the one CQC uses to carry out its clinical searches on inspection which would run alongside their existing system.

We did not find examples of effective medication reviews when we initially searched the records. However, the practice informed us that they had recently changed their system for this. We subsequently asked the practice for further evidence of the reviews and talked to members of the medicines management team. We saw the revised policy and which patient groups required which type of review. We saw that patients on repeat medicines were reminded to call the practice to arrange a review annually. We also saw that regular searches were used to identify who was due reviews. The practice sent us examples of 8 anonymised reviews that had been carried out appropriately using a template.

Several clinicians that we communicated with were very positive about the high quality of the information and support provided by the medicines management team,

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	98
Number of events that we looked at that required action:	3
Explanation of any answers and additional evidence:	
<p>There was a clear significant event process that all staff were aware of and involved in. We saw a document describing the significant events reported in the last year. We looked at 3 in detail and each was fully documented.. There was an analysis, learning points, agreed changes with completion dates and where necessary, reflections were recorded. Copies of letters were included where appropriate and a record that duty of candour had been followed.</p> <p>There were monthly significant events meetings with a lead GP, lead nurse, pharmacist, administrator and appropriate staff members. All clinical staff were invited. We were told that blame was not attached to individuals and learning was disseminated via emails to relevant staff. Where appropriate, some issues were further discussed at full staff meetings.</p>	

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

Event	Specific action taken
<p>Vaccination error – a patient had a first dose of hepatitis B vaccine in hospital following a needle-stick injury at work. They then required a subsequent hepatitis B vaccinations at Willesborough Health Centre. However, the hepatitis A vaccine was prescribed and given to the patient. The patient then had a further vaccination of hepatitis B at a later date.</p>	<p>A prescribing clerk identified the error. The drug company was contacted to confirm if the batch number related to either hepatitis A or B vaccine. The company confirmed that the batch number was for Hepatitis A.</p> <p>A significant event was raised and reported to the practice management and the drug company was contacted for advice.</p> <p>The incident was also reported to Public Health England. A significant event meeting was arranged, and the issue was discussed.</p> <p>The outcome was that vaccine checking procedures were strengthened and the patient received an apology. All appropriate staff were informed of the learning from this incident.</p>
<p>Early cervical smear – a nurse carried out an early repeat cervical screening out of protocol as they did not check the date</p>	<p>The patient was informed. A duty of candour letter was sent to the patient. Reflective learning was completed by the nurse</p>

of the previous screening. The sample was rejected by the lab.	including reading the cervical screening policy. The patient was informed of the correct recall date. The learning outcome was that nurses were to be more vigilant in checking the date of previous cervical screenings. The learning was cascaded to all appropriate members of the team.
Vaccine loss due to power failure - Two fridges at Singleton Health Centre were found to be reading very high temperatures on a Monday morning. It was found that there had been a power failure over the weekend. This resulted in a loss of a very large number of vaccines.	Fridges were moved to another room with back-up sockets. Vaccines were discarded as per the manufacturer's advice. The incident was reported to PHE (Public Health England). The fridge continuity plan was reread by the site supervisor. The learning outcome was that all fridges were to have back up sockets to prevent loss of vaccines. The incident was discussed as part of the practice training afternoon on what to do in the event of a temperature excursion, where to find the fridge failure continuity plan on the intranet and how to reset the fridges.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw a clear policy and comprehensive process was in place for the management of alerts such as the Medicines and Healthcare products Regulatory Agency (MHRA) and CAS (Central Alerting System) alerts. These were accessible to all staff on the team intranet.</p> <p>We saw a spreadsheet that maintained records of all the safety alerts received, the actions that were taken and by whom. Clinical staff told us that they received all new safety alerts via urgent email from the medicines management team.</p> <p>We saw a presentation that the Medicines Management Team had delivered to the practice that covered the matrix of the many systems, processes and audits that the team conducted to ensure the safe provision of medicines to patients. This included the management of new, current and historic safety alerts including MHRA and CAS alerts.</p> <p>During our clinical searches, we looked to see how many patients were on the combination of medicines omeprazole (to reduce acid reflux and stomach ulcers) and clopidogrel (a medicine which helps to reduce the risk of blood clots forming). Use of the two medicines together can reduce the action of clopidogrel. We found 4 patients who were prescribed this combination; 2 patients had been contacted to discuss the risk, but had declined to change medicines; and we could not see the other 2 patients were informed of the risks. After the inspection, the provider told us they had subsequently contacted the other two patients to discuss the risks and informed them of changes to their medication.</p> <p>We saw that the practice ran rolling audits on the management and use of 27 medicines or combination of medicines. The audits would be run between 1 and 4 times a year depending on the medicine. This included groups such as antimicrobials (antibiotics), DOACs and Opiates.</p>	

We also saw that as part of the protocol for the management of pregnant women, if a patient was coded as pregnant, a medication warning box appeared, and the medicines management team (MMT) were alerted. They would review their medicines and engage with the patient. When a new patient joined the practice, they would be referred to the MMT and their medicines would be reviewed including checking for any monitoring that may be required.

Effective

Rating: Good

At the last inspection in December 2021, we rated the practice as **Requires Improvement** for providing **effective** services because;

- There was inconsistent coding of patient clinical data.
- There was ineffective systems established to ensure safe prescribing and monitoring of patients with long term conditions.
- Some staff lacked training and autonomy to perform their roles effectively.
- There was no documented analysis or identified learning from clinical audits or patient surveys.

At this inspection, we found that those areas previously regarded as Requires Improvement had now improved. The practice is therefore now rated Good for providing effective services.

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated. ³	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	
Clinicians had access to current guidelines including the National Institute for Health and Care Excellence (NICE) guidelines. The medicines formularies such as the British National Formulary (BNF) and local formulary were all available on the computer desktop.	
The patient records that we looked at contained good, well-structured records of consultations.	

There were clear pathways for referral which allowed referrals under the fast access two week wait process (for possible cancer diagnoses) and urgent referrals to take precedence. Staff told us how they advised patients on changes to look for that should prompt them to seek further medical help.

The Primary Care Network (PCN) run by the provider Ashford Medical Partnership (AMP) and covering only the 3 sites run by Willesborough Health Centre, held meetings every 2 weeks with a multi-disciplinary team (MDT) from allied agencies to discuss the care of vulnerable patients. Examples of meeting minutes that we saw showed the team included members of the community nursing team, health and social care professionals, a frailty nurse, members of the rehabilitation team, a pharmacy technician, a social prescriber, a care co-ordinator and representatives from an elderly and dementia care support charity as well as GPs from the practice. We saw the minutes contained detailed records of patients, their histories and care needs under a patient identifier number. Actions were identified allocated and recorded.

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.
- 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. They were recalled annually and the GPs developed a care plan with them guided by a specific care plan template.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. They had a clinical pharmacist who specialised in mental health and a mental health support worker who reviewed the patients. They then had bloods taken and the GP saw the patient to develop a care plan with them.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The care co-ordinators maintained a list of patients receiving end of life care. Monthly meetings involved a GP, care co-ordinator, district nurse and members of the hospice team. Patients on this register had priority access to care.
- Where patients had multiple long-term conditions, the practice were moving towards combined appointments.

Management of people with long term conditions

Findings

During our inspection, we completed a series of searches on the practice's clinical records system. These searches were completed with consent and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance.

We completed searches on:

- rescue steroids in asthma patients. We saw that 151 patients out of 1574 with asthma, had received 2 or more courses of rescue steroids in the last 12 months for the management of acute exacerbations of asthma. We looked at the records of 5 of these patients. All 5 patients had been managed appropriately in line with accepted guidance.
- patients with chronic kidney disease (CKD) grade 4 or 5. We saw that 4 out of 98 patients identified as having CKD grade 4 or 5 potentially had not been monitored appropriately. We examined their records and found that all were being monitored in secondary care.
- patients with hypothyroidism. We saw that 13 out of 801 patients with hypothyroidism appeared to have not had a thyroid function test in the last 18 months. We looked at 5 of these patient records and found that 2 had been recalled, the practice explained the management of 2 other patients and 1 had not been recalled, the practice told us that they were recalling this patient for an appointment.
- diabetic retinopathy. Of 1955 patients who had been diagnosed with diabetes, 209 had retinopathy (a complication of diabetes affecting the vision) and their last HbA1c blood test was greater than 74. We looked at 5 patient records and saw all had been seen in the practice and reviewed in line with national guidance.
- asthma patients who had required more than 12 short acting beta agonists (SABA, inhalers for use in acute breathlessness due to asthma). We saw that of 1574 patients with an asthma diagnosis, 21 patients had required 12 or more SABAs in last 12 months. We looked at the records of 5 patients and found 4 had reviews this year and the other had been recalled recently. All the patients were being prescribed inhaled corticosteroids (to prevent acute asthma attacks) and all received the appropriate reviews and monitoring.
- We looked for the numbers of patients that may have had a potential missed diagnosis of diabetes. We found 1 patient in this category and they already had a telephone appointment booked to discuss the issue.

Examples of other findings:

- Patients with long-term conditions were offered an effective 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.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- 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 suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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, Hemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	404	430	94.0%	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) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	389	422	92.2%	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) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	387	422	91.7%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	386	422	91.5%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	398	449	88.6%	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

The practice met the minimum target in 4 of the childhood immunisation categories and were just below the minimum in the fifth category.

There was a staff member who recalled children for their immunisations. They ran a weekly report on who were due immunisations. Parents (or guardians) were sent 3 reminders by text and if there was no response, a letter. If there was still no response the health visitor would be informed who would look in to this further. There were also three-monthly meetings with the health visitor.

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)	72.9%	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) (UKHSA)	44.4%	63.4%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	63.7%	68.0%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	56.7%	56.4%	55.4%	No statistical variation

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Any additional evidence or comments
<p>We saw that recent published data from NHS digital showed their quarter one (Q1) 2022 (01 April to 30 June) cervical screening coverage performance for the Ashford Medical Partnership PCN was: 25 to 49 year age cohort (3.5 year coverage) 72%, 50 to 64 year age cohort (5.5 year coverage) 75.2%.</p> <p>The practice told us that they were currently achieving 92% but that data was not verified by CQC.</p> <p>There was a staff member who monitored cervical screening. If patients did not attend 3 appointments, they would be sent 3 text reminders and then a letter. They would also monitor the national database to see if there was any reason that patients may be failing to attend.</p> <p>There were two practice nurses who were undergoing training to carry out cervical screening and would qualify soon which would increase appointment availability.</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.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

Examples of improvements demonstrated because of clinical audits or other quality improvement activity in past two years

All of the work listed below was designed to improve outcomes to patients. They included an explanation as to why they had chosen to conduct the work, the background and guidance that they were following. Two of the audits were presented to staff as a learning presentation.

- The Medicines Management Team had produced a matrix of at least 27 rolling audits to ensure that high risk medicines and combinations of medicines were being appropriately monitored. Each audit had a summary page outlining the reason for the audit, the national guidance from which the recommendations were taken and the criteria that they measured against. It also showed the monitoring cycle and requirements. The medicines management team had presented this work at one of the practice learning days.
- A new system of review and audit of Medical and Healthcare products Regulatory Agency (MHRA) and Central Alerting System (CAS) alerts was introduced in January 2022. The system for receiving, disseminating, acting on all alerts, ensuring they were acting on all information pertinent to general practice and the system in place was for all categories of alert classes. This was a system of rolling audits that took in legacy and current MHRA alerts. All new patients were reviewed by the medicines management team when they transferred into the practice.
- An annual handwashing audit was carried out using the Hand Hygiene Audit Tool for General Practice. The purpose was to prevent the spread of infection between healthcare workers and patients. In the audit conducted in 2022, it was found all staff that were assessed had carried out the procedure appropriately. The audit was due to be repeated on an annual basis.

Any additional evidence or comments

- The practice received quarterly prescribing data for their non-medical prescribers from the local Integrated Care Board (ICB). They audited the data to review individual prescribing habits. This was to ensure that they were prescribing within their competency and that they remained competent. We were told that the information was forwarded to the clinicians' mentors for discussion at their reviews and individual clinicians told us that they were also given the data.
- A project had been carried out to look at the diagnosis of chronic kidney disease (CKD) within the practice. This was presented to clinicians at the practice with suggestions for improvement and actions to be taken to prevent progression. Learning from the event was emailed to all clinicians afterwards.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y

There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We looked at the training records for 10 staff members and found they were all up to date with mandatory training. Staff told us they were sent reminders when training was due and they had access to extensive online training. Staff were given protected time during working hours to complete their training.</p> <p>We also saw that the practice held Protected Learning Time (PLT) afternoons where a wide range of subjects were covered. Staff attended training for subjects appropriate to their role. Subjects included cancer, National Institute of Health and Care Excellence (NICE) updates, weight management, smoking cessation, headache and red flags, ECG (electrocardiograph) interpretation, first contact physiotherapist role, transgender issues, the management of aggressive patients, the significant event process, IPC (infection prevention and control), medicines management audits (including antibiotics), diabetes and complaints.</p> <p>There was a Clinical Supervision working group for Ashford Medical Partnership. This consisted of the GP Partner who was lead GP educator and trainer and lead trainer for GP registrars (qualified doctors who were in their final year of specialist training to be a General Practitioner). The team also consisted of a GP Partner who was a clinical supervisor and a nurse who was also a PCN (Primary Care Network) Community Education Facility Nurse.</p> <p>Each non-medical clinician had a mentor and there was always a GP (called a GP consultant) available for support and advise on site when they were working. Time was set aside during the surgeries to discuss any concerns or questions that the clinicians had. All prescribing was audited by the medicines management team and staff told us the results were fed back to individual prescribers with suggestions and advice. Staff told us that they were well supported by the GPs.</p> <p>There was a comprehensive induction programme tailored to the individual staff member. This lasted an average of 3 months, but this time period could be increased or decreased depending on the staff member's experience, ability and confidence to carry out the role. Staff that had been through the induction process told us that they felt supported by managers and their colleagues. Each new starter received a new starter guide which contained all the information that a new employee would require to help them settle in quickly and safely.</p> <p>We saw evidence that staff had annual structured appraisals and six monthly one to ones with their line manager or mentor. Staff told us that if they had concerns or requests, they could arrange additional one to one meetings.</p> <p>The staff handbook contained copies of the performance management procedures and we were shown a documented example of how this was used.</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.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider told us they had delivered approximately 20,900 Covid immunisations over the period of April 2021 to October 2022 as part of the national programme.</p> <p>They had also recently worked with Public Health England (PHE) following a diphtheria concern at a local immigration support unit.</p> <p>Whilst the practice had comprehensive care arrangements for their vulnerable patients living in care homes, they had identified that there may be patients living in sheltered accommodation that may be vulnerable due to possibilities of health inequality, such as access to services (including digital access). The practice arranged a meeting with the independent living officer. The outcome (with consent) was the referral of some residents for discussion at the PCN MDT meeting and positive healthcare and social care outcomes for 7 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.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y

Any additional evidence or comments

The practice had access to a Health and Well-being Coach who was employed by the PCN. They actively worked with local leisure centres to refer to their Exercise on Referral scheme. Referred patients received an 8-week programme to improve their conditions. Patients were primarily referred to the scheme for obesity, diabetes, respiratory and joint/ mobility issues to improve functional daily living and overall health. Once the course was completed, they were offered discounted membership for the

gym. The practice also worked to establish group exercise classes, for example for groups of patients with pre-diabetes or obesity to help provide social support networks.

Patients could be referred for smoking cessation and weight management programmes. The practice also provided NHS health checks where appropriate.

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Y
<p>Explanation of any answers and additional evidence</p> <p>We saw that the practice used templates where appropriate to record informed consent, in particular they were used when patients were having cervical screening, immunisations and minor surgery.</p> <p>There was a comprehensive DNACPR policy which was last reviewed in June 2022. We carried out a review of two sets of notes where a DNACPR decision had been recorded, one where a patient with capacity to make decisions themselves and one without. Patients' next of kin and power of attorney were involved in the decision. The procedure had been carried out appropriately in both cases and where possible the patients views had been sought and respected.</p> <p>DNACPR documents were stored either on the patient's records or if sent in by a third party (for example hospice, hospital or care home), they were scanned and saved to the document storage software (with a link recorded into the patient's records).</p>	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgmental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence:	
<p>Observation of staff during the on-site inspection and during the online and face to face interviews of both clinical and non-clinical staff revealed that staff shared a caring attitude and empathy towards patients. There was a genuine concern both from individuals and the whole team to find solutions to issues such as problems with access. We were told that if a patient made a verbal complaint, they could discuss it with a dedicated member of staff and would receive a further courtesy follow up call to check that they were happy with the response or ask if they could assist further. All verbal complaints were recorded.</p> <p>We were told by staff that they would treat patients with care, respect and dignity.</p>	

Patient feedback	
Source	Feedback
Feedback to CQC through the enquiry system	<p>CQC received 47 enquiries about Willesborough Health Centre in the last 12 months. Of these,</p> <ul style="list-style-type: none"> • 31 were complaints about access to services, in particular telephone access, • 6 were about prescription delays or other medicine issues, • 2 were concerned about staff attitude. • The remainder were about issues pertinent to the individual (7 of these were from 2 patients). <p>Some positive comments were made including staff being described as kind and helpful and doctors being described as helpful and thorough. In two instances staff were described as rude.</p>
Feedback from Patient Participation group (PPG) Taken from meeting minutes.	<p>Analysis of PPG meeting minutes revealed improvements could be made with communication of current issues and changes to patients. We saw the provider had taken on board some suggestions from the group and were exploring solutions. For example...</p> <p>There was further negative feedback about access. The practice described the reasons for the problem, the short-term actions that they had taken and potential medium to long term solutions. During our inspection, the provider told us they had received a positive response to the suggested solutions.</p>

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	73.3%	82.1%	84.7%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	72.1%	80.8%	83.5%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	83.4%	92.0%	93.1%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	41.0%	66.8%	72.4%	Variation (negative)

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

Any additional evidence

The GP Patient Survey was carried out independently for NHS England from 01 January 2022 until 30 April 2022, results were published on 14 July 2022. Survey questionnaires were sent to 599 patients of the practice and 197 were returned.

The practice sent out a text message after patients attended the practice encouraging them to complete a Friends and Family Test questionnaire.

If a patient wished to complain they were encouraged to speak to the patient services officers. We were told the practice received 40 to 60 verbal complaints a month which were recorded and helped the practice understand and resolve patient concerns.

The practice also monitored local social media comments and were in the process of devising a new online patient survey through their website, which they had discussed with the PPG at their last meeting.

They also surveyed patient call data to review why patients were phoning the practice and when, to help inform access planning.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence:	
<p>Easy read and pictorial materials were available.</p> <p>There was information on the website and in the waiting room to help patients find additional help from other agencies. The practice had two patient care co-ordinators who could help where appropriate.</p>	

Source	Feedback
Friends and family test results	<p>The provider shared data to show that from December 2021 to December 2022 after attending the practice, patients were sent an SMS text message or could fill in a form asking the question: 'Thinking About Your GP practice, overall, how was your experience of our service?'</p> <p>369 patients responded and the results were:</p> <ul style="list-style-type: none"> • 273 very good and 57 good (89.4%), • 14 neither good nor poor (3.8%), • 8 poor and 17 very poor (6.8%).

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	76.3%	89.0%	89.9%	Variation (negative)

Any additional evidence or comments

The practice were aware of the GP patient survey results and were trying to improve upon them. They had held several meetings to discuss ways in which they could be improved. There was a general understanding that there was significant patient dissatisfaction due to access issues. The practice had access meetings, with among others, 2 access partners and the general manager who met monthly to discuss and analyse this issue and had been actioning solutions.

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence:	
<p>The practice had access to interpretation services for patients where required and had hearing loops installed in waiting rooms.</p> <p>We saw that the practice held registers of their vulnerable patients which included the homeless, travelers, those with a learning disability, adults & child safeguarding. The practice also provided care to local sheltered housing. All patients listed within these registers were coded within the practice clinical system and had pop up alerts active on their record to inform staff of support provisions as necessary. The practice provided care for the residents of 6 care homes and residents of a home with learning disabilities.</p> <p>Patients in care homes had a dedicated GP who carried out twice weekly ward rounds and where necessary, dealt with any urgent daily issues. They also carried out comprehensive reviews and care plans and attended multi-disciplinary team meetings. After a ward round, the GP brought back a list of actions for the practice nurses and health care assistants to complete. Care homes have a direct line to one of the care co-ordinators and a separate email to contact them and the site manager.</p> <p>The practice complied with the accessible information standards.</p> <p>If there were changes in people's preferred gender, name, pronouns and title, an indicator would pop up when the patient's records were accessed to advise staff of this. The practice had a patient gender reassignment policy which was used when a patient had formally undergone gender reassignment.</p> <p>All surgeries had wheelchair access. Each surgery had accessible toilets that were suitable for use by people with mobility issues. Baby changing facilities were available.</p>	

Carers	Narrative
Percentage and number of carers identified.	The practice had 455 registered carers (1.3% of the practice population)
How the practice supported carers (including young carers).	One of the GP partners and one of the care-coordinators were the accountable persons for carers. Carers were registered with the practice and their notes and those of the cared for were flagged on the computer system to reflect this. Consent was gained to allow sharing of information with other agencies if they wished. Referrals would be made to carers support or social services where appropriate. Carers were offered an annual flu vaccination and if appropriate, an annual health check. Carer information was displayed in patient areas.
How the practice supported recently bereaved patients.	Bereaved patients were sent sympathy cards from the practice and a support letter was sent to the next of kin. An appointment would be made if the family wished to discuss anything with the GP.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:	
A private room was available between the reception desk and waiting room that was used if a patient wanted to speak to a staff member in confidence.	
Consultation rooms were lockable and all contained privacy curtains. Many staff were trained as chaperones, if either the patient or clinician requested one. There were notices throughout the building advising patients of this.	

Responsive

Rating: Requires Improvement

At our last inspection in November/December 2021 we rated the practice Good for providing Responsive services because people's needs were met through the way services were organised and delivered.

At this inspection in December 2022, we rated the Responsive domain as Requires Improvement. This was because:

- Although the practice had taken action to try and improve access, people still found it difficult to access services or book appointments, either by telephone or using the online system.
- Some people were not able to access services for assessment, diagnosis or treatment when they need to.
- There were long telephone waiting times reported by patients, and
- Action taken by the practice to address this had not yet been shown to be effective.
- The practice had been trying to recruit both clinicians and administrative staff so that they could provide access for patients at a level that could satisfy the demand but reported this had been difficult.
- CQC received 47 enquiries about Willesborough Health Centre in the last 12 months. Of these, 31 were complaints about access to services, in particular telephone access,
- The practice scored significantly lower than the England average in relation to GP Patient Survey results relating to access.
- Minutes from a recent Patient Participation Group meeting showed that there was still concern from patients regarding access to services,

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• A translation service was used to support patients for whom English was not their first language.• People with speech or hearing impairments were given a direct email address to contact the surgery and were able to approach reception desks for help.• There was an online consultation service available through the website.	

- The practice recorded information about any specific barriers patients may experience with access including digital illiteracy or disability to help improve patient care. To streamline further into a searchable list, they were in the process of moving to use an `Unable to perform information technology related activities` code to identify this group of patients and provide appropriate support.

Practice Opening Times

Appointments were bookable throughout the day between the following hours:

Day	Time
Opening times: Willesborough Health Centre	
Monday and Wednesday	8.00am to 8.00pm
Tuesday, Thursday and Friday	8.00am to 6.30pm
Saturday	9.00am to 5.00pm
Sunday	Closed
Opening times: St Stephens Health Centre	
Monday, Tuesday Wednesday and Friday	8.00am to 6.30pm
Thursday	8.00am to 8.00pm
Saturday and Sunday	Closed
Opening Times Singleton Health Centre	
Monday to Friday	8.00am to 6.30pm
Saturday and Sunday	Closed

The practice provided 16.5 hours a week of extended access appointments via the Primary Care Network (PCN) outside core hours across the 3 sites. These were included in the times above.

They had access to the Ashford improved access scheme where appointments could be accessed with GPs (not necessarily from their own practice) both at their practice and other Ashford surgeries.

Further information about how the practice is responding to the needs of their population

- Patients had a named GP.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Appointments were available outside of school hours so that school age children did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Appointments were available across all 3 sites from 8am until 8.00pm on a Monday, Wednesday and Thursday and from 9am to 5pm on Saturday. Pre-bookable appointments were also available

to all patients at additional locations within the area as the practice had access to an improved access scheme.

- The practice held registers of patients living in vulnerable circumstances including homeless people, Travelers, vulnerable migrants, sex workers and those with a learning disability.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- The PCN had employed a direct access physiotherapist.
- Patients could be contacted by phone, online consultation email and an SMS messaging system
- The practice hosted a dementia drop-in clinic in rotation with 3 other local surgeries.
- There was a dementia champion who supported patients living with dementia and their families.

Access to the service

People were not always able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	P
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	P
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y

Explanation of any answers and additional evidence:

There were 2 main ways to access appointments, via telephone and via an online service for non-urgent issues. Some vulnerable groups of patients could obtain access via email or a bypass telephone number.

The practice told us they fully recognised that access was one of their greatest issues. We also saw this was a standing agenda for discussion during the practice's monthly meetings. Access to the practice was the subject of many complaints; social media commentary and the GP survey results. It was also recognised as a source of pressure on staff.

The practice held monthly access meetings to discuss ways of improving access to services for patients. We saw minutes of an access meeting held in August 2022. The meeting was attended by senior management including 2 partners who led on access.

The practice recognised there were 2 aspects to access; contacting the practice and appointment capacity. The provider told us they had taken measures to try to improve both aspects.

The provider told us they had conducted regular audits of telephone activity. The provider shared data which showed that during a week in July 2022 the average number of calls was 2000 per day with 80% of those (1600) were being made between 8 and 9am. The audit also showed 55-60% of calls were for appointments.

The practice had calculated that assuming an average of 2 to 3 minutes to handle a call and accounting for repeat callers then they needed about 2500 minutes (42 hours) of staff time each day to answer calls satisfactorily.

We were told that over a number of weeks the practice used the call system to ask patients about the reasons for their calls.

The results were:

- 65% of calls were for GP appointments,
- 7% of calls were for nurse appointments,
- 4% of calls were to obtain test results,
- 3% of calls were for prescriptions queries.
- 11% of calls were for miscellaneous reasons,
- 10% of patients hung up or did not respond.

Using data gathered, action taken to improve access included:

- The call volumes and other data were constantly monitored on an overhead screen and a call escalation policy meant that all trained call staff could be messaged to help on the phone lines when extra capacity was needed.
- The practice had a call centre based at Willesborough but at peak times calls were routed to the branches as well to ensure that as many calls as possible were being answered.
- The practice operated separate lines for appointment line and the rest of their services. During peak times staff would only answer phones routed through the appointments line.
- A separate direct line to the medicines management team was set up for medicines issues.
- The queue length was adjusted from a maximum of 40 patients in the telephone queue back to 20 and then back again to 35 to try to minimise call drop-outs. The trial was ongoing to find the best balance.
- Econsult is a digital triage and online consultation platform used by the practice for non-urgent issues. The practice aimed to reply to patients within 72 hours. Its use was demand managed so that the practice could ensure that questions were responded to within that target time period.
- Additional staff had been employed to answer calls.
- All follow up appointments, ECGs, blood tests and blood pressure checks were booked by the surgery. Follow up appointments could be booked directly by the clinician.
- We were told that in view of the concerns that there would be a surge in cases of Covid, flu and Streptococcus A infections, the practice introduced a daily GP childrens' cough and cold clinic as part of their winter access initiative. Patients under 12 years of age with respiratory symptoms that parents were concerned about were given face to face appointments with appropriate infection prevention and control measures in place. A structured assessment was then carried out, with the parents being given written safety netting instructions at the end of the consultation. The clinics had been planned to run over the 3 months of increased winter pressures.
- The practice had been advertising for new clinical staff. and were able to recruit 2 long term GP locums and 2 salaried GPs . They had also employed a practice nurse, a nursing associate

and a trainee nursing associate. The provider told us they continued to advertise for clinical and administration staff.

- They were working to introduce a system that allowed normal test results, checked by a clinician to be sent to patients by a secure SMS text messaging system.
- The practice had documented criteria of vulnerable patients who would have priority access, should capacity be reached. This was built into the access policy.
- We were told that the practice had increased the ratio of face to face appointments to telephone appointments from 1:6 to 1:4 in view of the demand for more face to face appointments.
- The appointments team monitored the appointments system and changes had been made in response to demand.
- Some appointments could be made directly by NHS 111 and paramedics.
- The PCN had registered for a trial of a new self-booking and triage software option and was awaiting for confirmation from the Integrated Care Board (ICB).

We were told that eConsult (an online system of access for non-urgent issues) was monitored by a team who reviewed patient feedback (provided by econsult monthly) and trends. To ensure that patients received a response in a safe and timely manner, this was demand managed and was currently open online between 8am and 9am each day. This was kept under review. The practice benchmark was that all clinical econsult requests were contacted within 72 hours by a clinician. Patients were advised to contact the practice earlier if their condition changed. The benchmark for administrative queries to be resolved was 24 hours. We were told that 40% of current econsult capacity was met by partners doing clinics at weekends and evenings. This was in addition to the enhanced access capacity already delivered. In October practice data shows this to have been 680 extra appointments.

In the longer term, the practice was considering the implementation of an artificial intelligence online triage capability to improve access, improve patient and staff satisfaction, decrease call volumes and strengthen the ability to deliver the right appointments to patients. The provider told us they were consulting with practices that used these systems.

The practice had employed a consultancy company to assist with the project. The consultants specialised in helping health and local government services transform their services. The practice had informed their Patient Participation Group of the initiative.

On the day of the inspection we looked at the appointments system and saw the next available GP appointment was the next day (9 December 2022 at 8am). The next pre-bookable appointment across all three sites, either GP or Advanced Nurse Practitioner was 13 December 2022. The next practice nurse or healthcare assistant (HCA) appointment across all 3 sites was 15 December 2022.

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at	13.6%	N/A	52.7%	Significant Variation (negative)

Indicator	Practice	SICBL average	England average	England comparison
their GP practice on the phone (01/01/2022 to 30/04/2022)				
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	23.2%	48.6%	56.2%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	28.4%	48.2%	55.2%	Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	49.5%	68.2%	71.9%	Variation (negative)

Any additional evidence or comments

The practice was prioritising the issues that patients had with accessing care, particularly when trying to make an appointment via the telephone. They were aware of the GP Patient Survey data and had monthly meetings to explore ways to improve patient satisfaction. They were also aware of direct patient concerns and attempted to speak to all patients that raised a concern. All verbal (as well as formal, written) complaints were recorded and where possible the patient was offered a face to face meeting or a telephone call with a patient services officer to discuss their concern.

The practice also monitored local social media platforms to understand wider patient feedback.

Source	Feedback
NHS Choices	<p>Between January 2022 and December 2022 there were 15 reviews on the NHS Choices website. There were:</p> <ul style="list-style-type: none"> • 1 x 5-star review, • 1 x 4-star review, • 1 x 2-star review and • 12 x 1-star reviews. <p>The negative reviews described difficulty in accessing the service: patients had been waiting on the phone for a long time and there no appointments available when they spoke to a receptionist.</p> <p>The positive reviews described the service as fantastic, staff were friendly and helpful and the clinicians were good throughout the treatment.</p>
CQC Enquiries	CQC received 47 enquiries about Willesborough Health Centre in the last 12 months. Of these. 31 were complaints predominately about access to services, in particular telephone access,

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	49
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw that complaints were handled by a dedicated staff member who had undergone training in the management of complaints. There was a complaints policy and clear information on how to complain on the practice website and in the reception area at each site. We saw that complaints were handled in line with the practice's policy and in a timely manner. The records were complete and kept separate to clinical records. Duty of Candour was complied with. All complaints were initially responded to with a phone call to the complainant. If it was a formal complaint, an acknowledgement letter was sent to the complainant. Staff were aware that there was a direct email to patient services officers..</p> <p>Where possible all complaints were discussed with the patient. This was often followed up later with a further courtesy call. All complaints verbal and written were recorded. The patient services officer would have monthly meetings with the lead GP to discuss all complaints and relevant complaints were discussed at care meetings. Another member of staff was trained to cover the complaints administration role during staff absences.</p> <p>We saw that complaint outcomes were shared with staff who were involved in the complaint. We also saw relevant learning from complaints was shared with staff. Additionally, a proportion of the last 'all staff' training afternoon was devoted to the management of complaints. Some complaints were considered as significant events. In particular, the practice was very aware of patient concerns about access raised in complaints and had openly addressed the issue with staff.</p> <p>Nevertheless, the practice felt that learning from complaints could be more widely cascaded and from January 2023 were going to upload all informal and formal complaints to the team intranet and categorise them to allow easier analysis of trends and learning. We were told that the work had begun on this.</p>	

Example of learning from complaints.

Complaint	Specific action taken
Patient had a long delay in accessing a specific clinic.	There was a lack of clinicians trained to run the clinic at the time. The practice recognised the staffing issues and employed an appropriately trained clinician to cover, increasing the availability of appointments for that specialism

Well-led

Rating: Good

At the last inspection in November and December 2021 we rated the practice as Requires Improvement for providing well-led services because:

- there was a lack of staff involvement in developing the practice strategy.
- staff reported not being consulted on changes to their role and how this may have impacted on the delivery of services.
- management meeting minutes lacked narrative to demonstrate probity, challenge, actions and outcomes.

At this inspection, we found that these issues had been satisfactorily resolved. The practice is therefore now rated Good for providing well-led services.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
We found that the leadership understood the challenges related to access and had taken action to improve access for people using the service. For example, by looking at ways to increase appointments and reduce waiting times on the telephone. They had employed specialist consultants to advise and assist with their medium to long term plans to improve access.	
The practice had recently successfully completed a succession when the previous senior GP partner and the general manager stepped down from management of the practice. They were replaced by one of the partners who became senior partner and appointed a new general manager.	
Over recent years following practice mergers, the practice had become a large primary care at scale organisation (PCAS) with approximately 34,700 patients and the administrative structure of the practice had been identified as an area that should be reviewed. The leadership team were considering options in relation to this.	

Vision and strategy

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

	Y/N/Partial
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The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	
<p>We saw that the partners held monthly minuted meetings at which strategy was discussed, we saw from the minutes that the issues relating to strategy were to be discussed with all staff at a meeting the following month. We saw a presentation that showed the strategy was built on 4 pillars, these were patient outcomes, staff satisfaction and resilience, financial stability and resilience and regulatory compliance.</p> <p>Staff told us there was a 'whole staff' meeting held earlier in the year when they were informed that they would be introducing a new practice vision statement. Staff told us they were involved in decisions relating to this. The vision statement for the practice was displayed on the 'branches' home page of the practice website.</p>	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	
<p>All staff received a handbook which included information such as the disciplinary procedure, whistleblowing and the grievance procedure within the practice. This was also available via the intranet.</p> <p>Staff told us there was a no blame culture and they were happy to raise issues.</p> <p>The practice held events for staff such as Christmas parties and summer barbeques.</p> <p>When managing significant events and complaints the practice exhibited openness, honesty and compliance with the requirements of the duty of candour.</p>	

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

Source	Feedback
Staff interviews and feedback forms	Staff that we spoke with or who sent written feedback to us said they felt well supported both by managers and GPs and that there was an open-door policy. There were very positive comments made about the current management by some staff. Staff mostly felt listened to although some were unsure if the practice always took their suggestions onboard. Staff were positive about working at the practice and felt the team worked well together.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence:	
<p>There were clear governance structures and staff understood their roles and those of colleagues across the organisation. Each GP partner had several lead roles and an administrative team attached to each role. Where appropriate other clinicians were also part of the team.</p> <p>We looked at governance documents and found they were up to date. The provider had a system to help ensure the documents were reviewed regularly. Policies were dated, the name of the reviewer was noted, and the date of the next review had been recorded.</p> <p>We were told that a decision had been made to temporarily decrease the number of meetings so that only those focused on specific outcomes were held. This released staff to give them more time to devote to the work of the practice. Meeting minutes were made available to all appropriate staff and we saw that learning was disseminated via email. We did see that peer review meetings for the allied health professionals (non-medical clinicians) had restarted which staff told us was welcomed.</p> <p>We saw that meeting minutes were recorded appropriately, included the date and a list of attendees. Meeting agendas were circulated prior to the meetings and we saw that action logs were produced where appropriate which identified actions, the responsible person and a timescale. The log also recorded when the actions had been completed.</p> <p>There were appropriate governance arrangements for working with third parties with clear lines of contact.</p> <p>The practice felt that they no longer had backlogs of work following on from the pandemic and our observations confirmed that. For instance, we saw no backlog of investigation results or documents. Recalls for long term conditions and immunisations appeared to be up to date.</p>	

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<p>The practice had numerous policies and risk assessments that were reviewed regularly and updated as appropriate with a view to identifying and mitigating risks to patients.</p> <p>The practice had a comprehensive business continuity plan for major incidents such as; power failure or building damage. The plan included emergency contact numbers.</p> <p>There were issues that had been identified in recent fire risk assessments and Legionella water temperature testing at St Stephens Health Centre. The practice was following an action plan to resolve the issues.</p> <p>There was a quality assurance programme particularly around medicines management.</p> <p>We saw an example where the performance management and disciplinary procedure had been followed.</p> <p>The practice looked after a local support facility for the migrant population. The practice was involved with a suspected outbreak of diphtheria amongst the residents. The practice told us that within 2 hours of notification, they had set up an action group which worked closely with the Public Health England (PHE) team. The surgery managed to facilitate swabbing of all residents within the reception centre and provided the logistics and clinical staff for this. The clinical team also went out and assessed those patients who tested positive and risk assessed them based on PHE advice.</p>	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Regular medicine audits were carried out by the medicines management team, to help ensure medicines were being prescribed safely. Each prescriber was sent a regular audit of their prescribing with any potential anomalies highlighted for discussion with the medicines management team where appropriate.</p> <p>The access team monitored the telephone data daily to help plan the allocation of staff to the phone system.</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.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Records were retained securely. To access the records staff used a personal smartcard and password. Staff described how they secured their computers when moving away from their desk by logging out and removing their card. All rooms were lockable.</p> <p>Patients could access services online such as repeat prescription requests, appointment booking and the eConsult service. Patients required a username and password and could only access appointments and records personal to themselves.</p>	

Engagement with patients, the public, staff and external partners

The practice involved, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<p>The practice had an active Patient Participation Group (PPG) who had resumed face to face meetings following the pandemic. We saw minutes from the last two meetings in June and December 2022. We saw that the next meeting had been planned for March 2023.</p> <p>There was a PPG section on the practice website which contained copies of minutes and a sign-up form for patients. Meetings were attended by GP partners, the general manager and members of the PPG. We saw that comprehensive minutes were kept. From the minutes, we saw that the PPG were active fundraisers and the practice kept members aware of strategic changes that were taking place to the management of healthcare in the area. In the minutes we saw that the practice also kept the PPG informed of practice activities and changes. Access was an important topic at both meetings and the practice had described the issues and solutions. We saw there was discussion and members' views and questions were listened to and answered. The practice had plans to update the practice website so that patients could contact the PPG directly. The practice was also developing a new patient survey that could be accessed through the website.</p> <p>From the minutes we saw that PPG members felt that communication with patients could be improved. The practice agreed to look in to how this could be done and welcomed suggestions from the PPG.</p> <p>Staff described an instance where the practice responded to a patient concern. During the pandemic a patient with impaired hearing, who was unable to lip read whilst staff were wearing masks. In response staff wore clear masks and visors when talking to patients with a hearing impairment.</p> <p>We saw a copy of a presentation that was delivered to staff in June 2022 on improving the practice and involved staff in breakout groups to obtain their input and ideas on the creation of an induction pack, what data they required and a possible staff newsletter.</p>	

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: We saw examples of where learning was shared. The practice held regular training afternoons for all staff. Minutes from meetings, including learning	

points, were put on the intranet. Staff told us that updates were emailed to all members of staff individually. We saw there was a suite of training topics available to all staff and a system of monitoring to ensure that staff remained up to date with their training.

Examples of continuous learning and improvement

Learning and development was encouraged by the practice.

The practice encouraged staff to report significant events and staff told us that there was a no blame culture around significant events. Monthly meetings were held and learning was disseminated.

The practice had considered implementing a new software system to improve access and had employed consultants to assist with its assessment and implementation. They were also considering the use of a secure text messaging service to deliver test results and other information to patients.

One of the partners was a trainer for GP registrars (qualified doctors that were completing their GP specialist training) and the practice had 3 GP registrars. The practice was involved in the training of a trainee nursing associate and advanced clinical practitioner, both in conjunction with a local university.

We saw that the nursing team had sought the advice of the Nursing and Midwifery Council on a topic and a new policy was produced in response to their reply.

We saw the provider had a focus on staff personal development. For example,

- The cancer care coordinator (employed by Ashford Medical Partnership Primary Care Network but working solely at the practice) was undergoing training with a hospice organisation.
- A member of the pharmacy team had signed up for Advanced Care Practitioner training.

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 SICBL 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 SICBL average and is scored against the national target of 80%.

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

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

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ‰ = per thousand.