

Care Quality Commission

Inspection Evidence Table

Woodlands Surgery (1-549652687)

Inspection date: 1 – 4 November 2022

Date of data download: 02 September 2022

Overall rating: Good

At our previous inspections in September 2021, we rated the practice as requires improvement. This was because we found breaches of regulation in the Safe, Effective and Well Led domains.

At this inspection we found the practice had made significant improvements to processes and systems of accountability. Breaches of regulation had been reviewed and processes changed or improved to show that systems and processes were working as intended. There had been a collective approach to ensuring that improvements within the practice were sustainable. Managers and partners within the practice ensured best practice, performance and risk management systems and processes were in place. Governance processes were clearly set out, understood and effective.

Safe

Rating: Good

At our previous inspection the practice was rated as requires improvement because:

- An insufficient monitoring of a small number of patients who were prescribed medicines.
- A lack of monitoring of staff immunisations.
- Infection control concerns that had not identified in audits.
- Actions from the fire risk audit and electrical installation condition report still needing to be completed.

At this inspection we found:

- Patients who were prescribed medicines were being monitored and reviewed in the required timescales.
- Staff immunisations were centrally recorded and risk assessments were in place where needed.
- Recent infection prevention control audits had been conducted. During our onsite visit we found there were no infection control concerns. The practice was clean and organised with expiry dates being reviewed and recorded.
- Actions from the fire risk audit and electrical installation condition report were completed.

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

Safeguarding	Y/N/Partial
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>At our previous inspection we found:</p> <ul style="list-style-type: none"> Not all staff had the required training for safeguarding <p>At this inspection we found:</p> <ul style="list-style-type: none"> All staff had the required training for safeguarding. Staff we spoke with told us policies were accessible and the leads were knowledgeable and supportive if they needed to report any concerns. We noted in each clinical room there were details of who the safeguarding team were and how to contact them. The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. 	

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>At our previous inspection we found:</p> <ul style="list-style-type: none"> The staff immunisation policy did not include all of the required information. Staff had not received immunisation appropriate to their role nor in line with current Public Health England (PHE) guidance. The practice had not undertaken an assessment of the risks when they had been unable to confirm the immunisation of a staff member. <p>At this inspection we found:</p> <ul style="list-style-type: none"> The staff immunisation policy was up to date and held clear information in relation to which staff required what immunisation and how the practice would mitigate any risks if immunisation status was not known or if staff refused immunisation. Staff immunisation was clearly recorded and aligned with current guidance. All staff had received the required immunisation. We saw that if required a comprehensive risk assessment was available. <p>The provider had a recruitment policy in place which clearly outlined the recruitment process. We reviewed four staff files during our site visit and found these contained all relevant information, including proof of identity and disclosure and barring service checks to the appropriate level.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
There was a fire procedure.	Y
Date of fire risk assessment: May 2022 Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection we found:</p> <ul style="list-style-type: none"> The practice had completed a fire risk assessment by an independent company. However, some of the risks identified in the fire risk assessment had not been rectified in a timely manner and four were still outstanding. Not all staff had completed yearly training for fire safety and members of staff who were highlighted as fire wardens had not received training for the position or had completed it in the required timeframes. <p>At this inspection we found:</p> <ul style="list-style-type: none"> All of the risks identified in the fire risk assessment had been rectified and none were outstanding. All staff had completed yearly training for fire safety. Fire wardens had completed additional training for the role. 	

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. Date of last infection prevention and control audit:	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
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection we found:</p> <ul style="list-style-type: none"> The cleaning record for clinical equipment did not contain enough details to be effective. Hand hygiene and infection control had not been completed by all staff. During the CQC onsite visit we found infection control issues that had not been recognised during the infection control audit. For example, out of date stock, low level dust, and the lack of staff immunisation. Fridge temperatures were not being monitored daily, in line with practice policy. <p>At this inspection we found:</p> <ul style="list-style-type: none"> Cleaning protocols were in place and cleaning schedules included the frequency of cleaning and the individual tasks required. We saw evidence during our on-site visit that the cleaning schedules were being used, signed and dated when tasks were completed. All rooms contained a daily cleaning schedule for practice staff to follow which was signed and dated. 	

- All staff had completed training for infection prevention and control as well as hand hygiene. Staff we spoke with told us of ways in which they protected themselves from possible infection risks and that personal protective equipment was always available.
- During the CQC onsite visit, we found no areas of concern in relation to infection prevention and control. Rooms were clean, well organised and clutter free.
- The practice was using technologies to ensure that the recording of fridge temperatures was assessable to all staff members involved in the task. The new way of working ensured that anyone within the practice could see if a task had not been completed and therefore take any necessary action.

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	Y
Explanation of any answers and additional evidence: Staff we spoke with were able to articulate what red flag symptoms meant and what actions they would take should they encounter them from patients. Sepsis and red flag symptoms information was readily available for reception staff.	

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:	

At our previous inspection we found:

- A very small number of patients did not show that test results had been monitored and therefore may have had a missed diagnosis.

At this inspection we found:

- Our review of patient records in relation to clinical searches found that information was recorded appropriately to support the safe care and treatment. Test results were reviewed by doctors and any diagnosis was being appropriately recorded in a timely manner.

Our review of patient records indicated care records were managed in line with current guidance and that information, including, examination, management plans, safety netting and follow up were adequately documented.

The practice had a system for monitoring two week wait cancer referrals. DNACPR records were complete and recorded correctly.

Appropriate and safe use of medicines

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

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	1.04	0.73	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	8.9%	9.9%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)	6.03	5.90	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	61.4‰	76.1‰	128.0‰	Tending towards variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.65	0.70	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	4.1‰	5.4‰	6.8‰	Tending towards variation (positive)

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 structured 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
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>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>At our previous inspection we found:</p> <ul style="list-style-type: none"> A small number of patients who were prescribed a medicine to treat high blood pressure and heart problems who potentially had not undergone the required monitoring, <p>At this inspection we found:</p> <ul style="list-style-type: none"> Our searches indicated that patients we reviewed had received the required monitoring in line with current guidance. Our searches indicated that, of 1,049 patients prescribed a medicine to treat high blood 	

Medicines management	Y/N/Partial
<p>pressure and heart problems, only 5 patients may not have had the required monitoring. We reviewed all of the 5 patient records. We found that 2 patients were not in the country, 1 patient was being monitored externally by another health care provider and 2 patients had an appointment booked for a weeks' time. We noted that all patients had been sent a number of reminders to attend the practice for monitoring and where necessary the practice had reduced the number of prescriptions to ensure compliance.</p> <p>During our on-site inspection we reviewed the emergency medicines. We found that the emergency medicines were appropriate, and dedicated staff members were required to monitor stock levels and expiry dates. This included emergency oxygen and the defibrillator. Staff we spoke with were aware of where emergency medicines were situated.</p> <p>Vaccines were stored appropriately, and their expiry dates were checked and audited.</p>	

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:	2
Number of events that required action:	2
<p>Explanation of any answers and additional evidence:</p> <p>Staff we spoke with knew how to report incidents and significant events and were able to share examples of learning from them.</p> <p>We saw from the minutes of practice meetings that incidents were a standing agenda item and had been discussed with all staff members to support learning and improvement. Staff were encouraged to voice opinions on how incidents could be avoided, or systems improved for the future. Details of incident discussions were clearly minuted to allow staff members not present at the meeting to understand the nature of the incident, the discussion and any actions taken or required. Staff we spoke with told us discussions were of an open nature and there was a no blame culture. They told us they would be confident to raise an incident or significant event so that learning could be widely shared.</p>	

Example of significant events recorded and actions by the practice.

Event	Specific action taken
Referral not completed	<p>Patient apologised to</p> <p>Referral sent as urgent and patient given appointment for the next day</p> <p>Discussed at practice meeting</p> <p>Staff members reminded to ensure referrals given to secretaries to process</p>

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>The practice had an effective mechanism in place for the actioning of safety alerts. From a sample of patients' records we reviewed, we found action had been taken on all recent alerts, and systems ensured the provider continued to audit medicines previously subject to safety alerts, to ensure prescribing continued to be in line with up to date guidance.</p>	

Effective

Rating: Good

At our previous inspection the practice was rated as requires improvement because:

- There were gaps in staff training which was a repeated breach from the inspection in February 2019.

At this inspection we found:

- All staff training was up to date. Staff we spoke with told us they could have protected time during their working day or complete training at home if they wanted. This ensured training was up to date.

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 had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence: Clinical staff we spoke with were able to describe how they kept up to date with evidence-based practice. Staff we spoke with and minutes of meetings we reviewed evidenced that clinical issues were regularly discussed between members of the team at practice meetings. Our clinical searches found patient's care and treatment was regularly reviewed and monitored. For example, in relation to high risk medicines and long-term conditions.	

Effective care for the practice population

Findings

The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

All patients with a learning disability were offered an annual health check.

End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

The practice demonstrated that they had a system to identify people who misused substances.

The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder

Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

Staff who were responsible for reviews of patients with long-term conditions had received specific training.

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, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	80	91	87.9%	Below 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) (NHS England and Improvement)	89	105	84.8%	Below 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) (NHS England and Improvement)	90	105	85.7%	Below 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) (NHS England and Improvement)	89	105	84.8%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	86	108	79.6%	Below 80% uptake

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 childhood immunisation data is impacted by the low number of eligible children registered at the practice.

The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation, and would liaise with health visitors when necessary.

The practice looked after patients from an immigration centre. These patients were encouraged to bring their children for immunisation. However, it was acknowledged that these patients were a hard to reach group and the practice along with the primary care network were working to help promote access to mental and physical health care and support to these patients.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	69.0%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	61.7%	62.5%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	68.6%	69.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	60.7%	56.8%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments

The practice continued to review the uptake of cervical screening. Nurses ran cervical screening clinics, as well as providing ad hoc cervical screening. The practice contacted eligible patients for cervical screening via a letter and a phone call to influence patients to attend their appointments. Non-attenders were flagged on the patient's record so that the screening test could be discussed opportunistically. The practice was able to offer evening and weekend appointments.

We noted that the uptake of cervical screening had improved from our last inspection in September 2021 from 66% to 69%

The practice looked after patients from an immigration centre. These patients were encouraged to attend cervical screening. However, it was acknowledged that these patients were a hard to reach group and the practice along with the primary care network were working to help promote access to mental and physical health care and support to these patients.

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 improvement activity in past two years

Any additional evidence or comments

We found there was a comprehensive programme of clinical audit and second cycle audits. For example, there were audits of prescribing and medicines management audits undertaken. Audits had also been completed for adrenaline auto-injectors in children, antimicrobial stewardship and patients with long term conditions.

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

Explanation of any answers and additional evidence:

At our previous inspection we found:

- Not all staff had completed the required training. For example, there were gaps in training for adult basic life support, Deprivation of Liberties (DoLs), infection control, General Data Protection Regulation (GDPR), preventing radicalisation, Safeguarding Vulnerable Adults and Safeguarding Children.

At this inspection we found:

- All staff had completed the required mandatory training as required by the practice. This included adult basic life support, DoLs, infection control, GDPR, preventing radicalisation, Safeguarding Vulnerable Adults and Safeguarding Children.

Online training was available for staff members, who told us they could have protected time during their working day or complete the training in their own time. Reminders were sent if training was due which allowed staff to plan their time accordingly to ensure training was completed in a timely fashion.

Staff we spoke with told us how the practice was supportive of training and development to meet the needs of the service.

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>Vulnerable patients were supported through the anticipatory care programme. Weekly multi-disciplinary team (MDT) meetings were held. Meetings included care coordinators, community matrons, district nurses, GPs, the wellbeing team, palliative care nurses, a pharmacist, social services and a consultant geriatrician. The practice was also able to invite specialist nurses for old age psychiatry, dementia, Parkinson's and heart failure, as well as dieticians, occupational therapists and community physiotherapy if needed. During the meeting patients who were unwell, or deteriorating were reviewed as well as reviewing care plans of stable frail patients. Patients could be referred into this service by any member of the MDT team and their initial assessment was carried out by the community matrons who could bring in wrap around care, support and treatment for the patients on a same day basis if needed to help support patients at home.</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
<p>Explanation of any answers and additional evidence:</p> <p>Staff worked collaboratively to understand and meet the range and complexity of patient's needs.</p>	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	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
Explanation of any answers and additional evidence: Staff supported patients to live healthier lives. There was a focus on early identification and prevention and on supporting patients to improve their health and wellbeing.	

Responsive

Rating: Good

Access to the service

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

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y
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	Y
There were systems in place to support patients who face communication barriers to access treatment	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: The practice website was up-to-date and included information about how to book an appointment, what to do in an emergency or when the practice was closed. The website included information about a range of local community-based services and services to which patients could self-refer. Patients could request repeat medicines and appointments via online services.	

Well-led

Rating: Good

At our previous inspection the practice was rated as requires improvement because:

- Governance systems remained ineffective and leaders had insufficient oversight to identify when processes were not working as intended. The practice was unaware that some of the repeated risks identified at the last CQC inspection had not been resolved adequately.

At this inspection we found:

- Governance systems were effective, and leaders had oversight to ensure processes were working as intended.
- Leadership, management and governance ensured the delivery of high-quality and person-centred care, supporting learning and promoting an open culture.
- There was collaborative team-working to support and help improve the quality and sustainability of care.
- The practice ensured staff at all levels had the skills and knowledge to use systems and processes effectively. Risks were identified and addressed openly.

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 saw evidence of clinical and managerial leadership within the practice. The practice worked with the local practices within the primary care network (PCN) to understand local challenges to quality and sustainability to develop services. (PCNs have the potential to benefit patients by offering improved access and extending the range of services available to them, and by helping to integrate primary care with wider health and community services). Staff we spoke with and received feedback from, commented leaders were very approachable and supportive for both work and personal issues. Staff were proud of the practice as a place to work and spoke highly of the culture.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	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
<p>Explanation of any answers and additional evidence:</p> <p>Leaders were aware of the improvements needed and practice staff had worked as a team to improve processes to ensure they were working as intended. There was an understanding of what the challenges were, and leaders had put actions in place to address them.</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
<p>Explanation of any answers and additional evidence:</p> <p>Staff feedback was extremely positive. Staff told us of an open culture and that they could raise concerns, questions or suggestions and that these would be listened to. They told us communication was a two-way process and felt involved with the running of the practice. Managers within the practice told us that staff well-being was a priority which was evidenced from feedback we received.</p>	

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

Source	Feedback
<p>Staff interviews via Teams meetings.</p> <p>Face to face conversations.</p> <p>Staff questionnaires via email.</p>	<p>Staff members we spoke with during the inspection reflected positively on the culture within the practice. They told us morale was high and all leaders, managers and GPs were approachable.</p> <p>Many staff had worked at the practice for a number of years and reported there was a strong team ethos.</p> <p>Staff members commented positively on the opportunities to learn and develop. We were told that ideas and suggestions were welcomed by leaders and we heard of examples where suggestions had been acted upon.</p>

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
Explanation of any answers and additional evidence: There were clear roles and accountabilities. Staff knew who different leads were within the practice and who they could go to if they had any concerns.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	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: At our previous inspection we found: <ul style="list-style-type: none">Some systems required strengthening to ensure identified risks and actions taken were working as intended. Governance systems needed to be monitored to ensure they were being effective. For example, oversight of staff immunisations, infection prevention and control audits, training, and actions required from risk assessments. At this inspection we found: <ul style="list-style-type: none">The practice had made improvements, and processes had been put in place to ensure systems were working as intended. We saw evidence that governance systems had been reviewed and were now effective. For example, staff immunisation and training was up to date, actions from audits and risk assessments including infection prevention and control and fire safety had been completed and all were centrally recorded.	

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

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

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>At our previous inspection we found:</p> <ul style="list-style-type: none"> Leaders in the service were unaware that some of the repeated risks identified at the last CQC inspection had not been resolved adequately. <p>At this inspection we found:</p> <ul style="list-style-type: none"> The information used in reporting, performance management and delivering quality care was monitored and reviewed by leaders and staff within the practice. This ensured that any risks identified were used to improve performance of the practice. 	

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	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
<p>Explanation of any answers and additional evidence:</p> <p>We saw that staff feedback and views had been taken on board and acted upon. Staff told us that they felt able to suggest improvements to the management team and that these were listened to.</p> <p>We spoke with managers in relation to the patient participation group (PPG). They explained that due to differing factors the group membership was low. They were discussing different ways to promote the PPG to the different patient demographics in order to gather wider opinions. They were also considering a joint PPG incorporating patients from the different practices within the primary care network.</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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a programme of audits to review services and identify areas for improvement. Complaints and significant events were regularly discussed and used to support learning and improvement.</p>	

The practice continued to review ways of working to improve access.
 The practice had access via the PCN to paramedic practitioners and practice pharmacists, to improve the patient experience.
 The practice had access to a social link prescriber, who was able to do home visits to assess the patients in their own homes to enable better care.
 The practice was working on projects with local practices within the primary care network (PCN) to support hard to reach patient groups.
 The practice held joint weekly multi-disciplinary team meetings with the PCNs. Meetings included care coordinators, community matrons, district nurses, GPs, the wellbeing team, palliative care nurses, pharmacists, social services and a consultant geriatrician.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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