

Care Quality Commission

Inspection Evidence Table

Chilcote Surgery (1-545478417)

Inspection date: 1 November 2022

Clinical Searches 27 October 2022

Date of data download: 17 October 2022

Overall rating: Good

Chilcote Surgery was previously rated as good overall in January 2019.

Safe

Rating: Good

At the last inspection in January 2019, we rated the practice as good for Safe.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence: The practice had a safeguarding lead GP and a deputy who oversaw all safeguarding concerns. Safeguarding risk registers were maintained, and staff were made aware of children 'at risk'. Meetings were recorded to ensure an audit trail of discussion and we saw that any actions needed were completed.	

Safeguarding	Y/N/Partial
Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
Explanation of any answers and additional evidence:	
We reviewed a random sample of three recruitment files, including the newest member of staff. All necessary recruitment information was appropriately obtained.	
Clinicians who were required to register with a professional body had evidence to demonstrate they were up to date with their registration.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 17 June 2022	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 17 June 2022 Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence:	
The practice had completed Personal Emergency Evacuation Plans (PEEPS) for staff that had impaired mobility.	
There were designated staff who were trained as fire wardens, and we saw regular fire drills were carried out, the last fire drill was on 28 October 2022	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 23 February 2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence:	

On the day of the inspection we found the building to be clean and hygienic throughout.

All staff were up to date with infection prevention and control training (IPC). The lead practice nurse undertook regular audits and ensured staff were up to date with the most recent guidance and information. For example, some liquid soap dispensers were found not to be mounted to the wall however we saw evidence this had been actioned. .

For patients and staff, alcohol gel was located at the entrance and throughout the building. There was signage reminding people to use the hand gel. The practice had taken action to follow national guidance to reduce the number of patients attending the practice during the COVID-19 pandemic.

In treatment rooms sharps boxes were dated and signed when first in use and again when ready for disposal. This enabled an audit trail of their use.

All electrical equipment had stickers identifying that servicing and checks were in date.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
Explanation of any answers and additional evidence:	
Staffing levels were planned to ensure there was enough coverage for periods of leave such as annual leave or to cover sickness. Temporary staff were provided if there was a shortage of practice staff, they had a full induction to ensure they were able to work safely.	

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	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence:	
Review of patient records in relation to the clinical searches identified that care records were up to date managed in line with current guidance.	
The practice had a system to manage test results and ensured prompt clinical oversight of the tests. If the requesting clinician was not available to review the results, another GP would ensure the results were seen and actioned.	

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) (01/07/2021 to 30/06/2022) <small>(NHS Business Service Authority - NHSBSA)</small>	1.02	0.81	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total	9.3%	8.9%	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). (01/07/2021 to 30/06/2022) <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 (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	6.61	5.74	5.31	Variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	233.5‰	139.2‰	128.0‰	Tending towards variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) <small>(NHSBSA)</small>	0.86	0.72	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	8.9‰	7.4‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
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	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. ²	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes

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.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
Explanation of any answers and additional evidence, including from clinical searches.	
<p>We undertook searches on the practices clinical system to review the monitoring of patients on specific medicines and the care required relating to taking those medicines. We found 423 patients on Gabapentonooids (these are medicines used to treat epiliespy, anxiety and nerve pain) with 101 patients (24%) who potentially had not received an appropriate review in the last 12 months. We reviewed five patient records which showed all five patients had received a review within the previous 12 months, one patient was under secondary care and having their dosage monitored by a pain specialist, and another patient was six months out of review date however their dosage had been monitored. We saw the practice took steps to encourage patients to have a review of their medication however due to the practice population groups over 20% of patients declined to engage. The practice provided additional weekly care and support to the vulnerable homeless population of Torquay.</p>	
<p>The practice were aware of the high prescribing of pregabalin and gabapentin which can become addictive. The practice had recently employed two pharmacists who were in the process of reviewing all patients prescribed these medicines. They were contacting patients and discussing a plan to reduce the medicines over a period of time or to prescribe an alternative and had been able to reduce the prescribing level by 28%. This was an ongoing prescribing quality improvement programme by the practice.</p>	
<p>The practice had Patient Group Directives (PGDs) in place, which meant that all clinical staff administering medicines were authorised to do so. However, the practice did not follow the guidance of crossing out the unused rows in the list of practitioners post managerial sign- off The practice immediately corrected the PGDs that were affected on the day of the inspection.</p>	
<p>As part of the inspection a number of clinical searches of patient's records were undertaken remotely by a Care Quality Commission (CQC) GP specialist advisor (SpA). The GP SpA found the results from the searches undertaken were positive, particularly given the challenges of service provision during the pandemic.</p>	
<p>We looked at medicine reviews for five patients and all of these patients had detailed medicine reviews.</p>	

Medicines management	Y/N/Partial
Patients prescribed high risk medicines, such as Azathioprine, (a type of medicine that helps patients with rheumatoid arthritis, crohns disease and ulcerative colitis) were being appropriately monitored.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	15
Number of events that required action:	13
Explanation of any answers and additional evidence:	
The practice had a system for identifying and recording significant events and demonstrated that there were actions and learning associated with these. The practice showed us that they discussed these in meetings and the learning was shared with staff.	

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

Event	Specific action taken
A patient queried their prescription of a Hormone Replacement Therapy (HRT) as the name on the packaging was slightly different from the previous HRT they were prescribed.	Following a review of the medicines it was found that the patient was correct, the prescribed medicine had a slight change of name to the previous HRT. A new prescription was immediately actioned and all patients on HRT were reviewed to ensure they were on the correct named medicine.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. ¹	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	
We saw examples of actions taken on recent alerts, for example, we reviewed five patient records to ensure safety alerts were acted upon:	

Of the five patients who were taking Angiotensin Converting Enzyme inhibitors (ACEi) or Antigtensin Receptor Blockers (ARB) (these are medicines used to treat high blood pressure and heart failure) we found patients were monitored on a regular basis and were having annual blood tests.

Effective

Rating: Good

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.

At the last inspection in January 2019, we rated the practice as good for Effective.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated. ³	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice prioritised care for their most clinically vulnerable patients.	Yes
Explanation of any answers and additional evidence:	
In the searches we carried out, we found patients were regularly reviewed where possible and recalled for monitoring of any diagnosed conditions. Upon reviewing the clinical system, we found that patients notes were detailed and any test results or documentation received was reviewed and acted upon in a timely manner.	

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.
- 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.
- The practice was part of a wider Primary Care Network (PCN) which included various roles that could support patients at Chilcote Surgery: for example, there was a physiotherapist, a dietician and two social prescribers.

Management of people with long term conditions

Findings

We carried out remote clinical searches and sampled a number of patient records to establish that the management of long-term conditions was effective. We checked to ensure that required assessment and reviews were taking place. The records we examined provided clear and detailed evidence that patients had been monitored and reviewed appropriately.

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met this was not always possible due to the patient population group . 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.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

- 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)	103	108	95.4%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	106	113	93.8%	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) (NHS England and Improvement)	105	113	92.9%	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) (NHS England and Improvement)	106	113	93.8%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	108	120	90.0%	Met 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

Staff who were involved in the childhood immunisation programme were knowledgeable about the process and were flexible to meet the needs of the families.

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.

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: 31/03/2022) (UK Health and Security Agency)	75.5%	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)	73.3%	66.5%	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)	69.2%	71.4%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	50.4%	56.6%	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 asked the provider about the low uptake rates for cervical screening. We were advised the practice was offering extended clinic appointment times, patients were also being contacted by letter and text message to ensure they could make an appointment.</p> <p>Following the inspection the practice provided unverified data from their clinical system showing an increase in the uptake of cervical screening for the date 31 March 2022. For persons aged 25-49 the percentage uptake was 84%, for persons aged 50-64 the uptake was 82%.</p> <p>The practice held “new cancer diagnosis” monthly meetings where support for patients and families was discussed along with learning points from referrals to secondary care.</p>

Monitoring care and treatment

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

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

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

Any additional evidence or comments
<p>The practice had a comprehensive approach to monitoring quality of care, which included an expansive audit programme:</p> <p>An audit was carried out in September 2022 on patients who required a urine dip test for microscopic hematuria (blood in the urine) and to ensure they were being followed up and processed in a timely manner. The audit was carried out over two days with twenty nine samples being taken, 15 of these were dip tested, and nine specimens followed the practice protocol. This audit identified that five specimens had been sent straight to the laboratory without having a dip test first.</p> <p>The protocol was reviewed to ensure nurses dip tested urine samples before sending them to the lab and a note was sent to the GP confirming the process had been followed. The audit is to be re-done in six months' time.</p> <p>The practice purchased two blood pressure machines for use in the reception area at both Chilcote Surgery and the branch surgery Chatto. This was to improve the number of new hypertension (high blood pressure) diagnosis. Patients were invited in by text and given a form to complete following the blood pressure reading. If their reading was greater than 180/100 the patient was asked to wait to see a GP. If greater than 140 systolic (this indicates how much pressure your blood is exerting when the heart beats) they were invited for home blood pressure readings. Following an audit between 1 March and 1 June 2022 it identified 40 new cases of hypertension which shows the benefits of having the blood pressure machines within the practice.</p>

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence:	

Staff had regular appraisals and the practice management team had an open-door policy. Staff told us they felt supported in their roles and were able to speak to the management team when needed.

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Staff are consistent in supporting people to live healthier lives, including identifying those who need extra support, through a targeted and proactive approach to health promotion and prevention of ill-health for example:</p> <ul style="list-style-type: none"> • The practice joined two other practices in 2019 to form the Baywide Primary Care Network (PCN) which covers the areas of Paignton and Brixham. The PCN is able to deliver working at scale projects such as a Care Home Visiting Service and Extended Access . • Chilcote Surgery has been able to facilitate a drug and alcohol support worker who will also be working with the other practices within the PCN to support patients who are under the drug and alcohol service, the homeless people and those who have issues with polypharmacy (polypharmacy is the simultaneous use of multiple medicines for a condition). • The practice has also been involved in work with the breastfeeding strategy group to improve breast feeding rates in the local community, which involves working with multiple agencies such as: public health , the midwifery team, and action for children. 	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence:	
The practice had a GP who was the palliative care lead and there were weekly meetings held which included the community teams.	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Yes
Explanation of any answers and additional evidence:	
Our clinical review of notes where a DNACPR decision had been recorded, had identified that patients' views had been sought and respected. We saw that information had been shared with any relevant agencies where necessary.	
Staff we interviewed shared examples of how they obtained consent and where they recorded this within standardised assessment templates, this included the discussion of any risks and the benefits. For example, before carrying out a cervical screening procedure.	

Well-led

Rating: Good

At the last inspection in January 2019, we rated the practice as good for Well Led.

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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence:	
The leadership team demonstrated an understanding of the challenges they faced such as a growing patient list (over 300 patients registering within October) and a difficulty in recruiting clinical staff .	
The practice had a strong passion for succession planning and encouraged staff to take ownership of their personal development through training and upskilling. Staff told us they had protected time to complete the required training and were able to discuss future development needs with their line managers.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence:	
The practice held monthly staff meetings and nurse meetings, as well as regular clinical, management and business meetings. Changes were discussed and shared with staff at these meetings.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Staff we spoke with are proud of the organisation as a place to work and spoke highly of the positive culture. Staff at all levels were actively encouraged to speak up and raise concerns, all policies and procedures support this process.</p>	

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

Source	Feedback
Staff Interviews	Staff we spoke with told us that the management team were approachable and they felt listened to. Staff told us they enjoyed their job and staff morale was good within the practice.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence:	
The practice had a clear system in place for recording complaints and we found timely responses were given, patients were contacted by telephone and a letter to acknowledge the complaint before a full response was sent.	
The system for managing significant events was clear and effective, staff told us they were involved in discussing the events and the learning was shared through meetings and updates.	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence:	
There was a programme of clinical audits in place to monitor the quality of care and outcomes for patients.	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Staff are supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence:	
The practice had made changes to its information technology (IT) to improve efficiencies and workflows by embracing new digital tools, for example: AccuRx (a text messaging service), Ardens (a clinical resource template) and Clarity TeamNet (a software programme that streamlines workforce operations).	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group (PPG)	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence:	
During the Covid-19 pandemic, the PPG group dismantled, however the practice does have a virtual PPG group.	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: Staff we spoke with told us the provider was encouraging and supportive when they approached about further training to enhance their roles. The practice provided placements for registrars training to be qualified GPs.	

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.