

# Care Quality Commission

## Inspection Evidence Table

### Church View Practice (1-7586826993)

Inspection date: 8 April 2021

Date of data download: 06 April 2021

## Overall rating: No rating given

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

## Safe

## Rating: No rating given

### Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
Explanation of any answers and additional evidence: The local clinical lead salaried GP, was the designated lead member of staff for safeguarding processes and procedures within the practice. They were present in the practice on four days each week. Staff told us that another member of staff, one of the practice nurses, was present in the practice on the fifth day and acted as deputy lead member of staff for safeguarding processes and procedures during that time. Records showed that this member of staff had been trained in safeguarding to an appropriate level for their role. Since our previous inspection, the role of deputy lead member of staff for safeguarding processes and procedures had been clearly outlined within an addendum to that staff member's job description. We found that the addendum had been signed by that staff member to confirm their understanding and acceptance of the role. The provider's safeguarding policy for adults, young persons and children outlined who to contact for further guidance if staff had concerns about a patient's welfare. The policy provided details of the head of nursing and the group medical director as the organisational leads for safeguarding.	

Safeguarding	Y/N/Partial
<p>At this inspection we found that the policy had been updated to provide an appendix which detailed the local designated lead members of staff for safeguarding processes and procedures within the practice.</p> <p>We saw that the completed appendix was clearly displayed within the practice to provide contact details of the local clinical salaried GP and the practice nurse, who held those lead roles. We found that additional guidance displayed within the practice provided staff with contact details of local authority and clinical commissioning group safeguarding teams.</p>	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
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:	Yes 12/11/2020
The practice had acted on any issues identified in infection prevention and control audits.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>During our inspection on 8 April 2021 we saw that all relevant staff had access to personal protective equipment (PPE) and were adhering to current best practice guidance on COVID-19. For example, wearing face coverings and keeping a distance from others. Hand sanitising gel was available throughout the practice for patients, staff and visitors to use.</p> <p>There was a lead member of staff for infection prevention and control within the practice who was up to date with infection prevention and control training appropriate to the role. Staff told us that since our last inspection the provider had appointed a head of nursing who worked across the organisation. The head of nursing was also the lead for infection prevention and control within the group.</p> <p>At our previous inspection we saw that an infection control risk assessment had been carried out on 25 June 2020 by the practice manager. The risk assessment did not identify risks in any detail other than by use of general headings. For example, the environment, specimens and toilets. The risk assessment contained control measures to reduce infection prevention and control risks.</p> <p>The provider's infection prevention and control policy required the practice manager and nurse lead to provide an annual audit of the practice's infection prevention arrangements using appendix three (infection control audit for general practices form). We saw that appendix three was the risk assessment tool which had been completed on 25 June 2020.</p> <p>At our inspection on 8 April 2021, we found that a revised risk assessment had been completed on 12 November 2020. A list of control measures under each of the general headings had been used to confirm monitoring of infection prevention and control processes. We saw that one action had been identified and documented in relation to the storage of sharps bins. This action had been reviewed and marked as completed on 31/12/2020. Our review of the storage of sharps bins within the practice confirmed that this action continued to be complied with.</p> <p>Staff told us that the provider had developed a more comprehensive infection prevention and control audit tool which was in the process of being rolled out across the group of practices. The head nurse</p>	

and lead for infection prevention and control told us they were supporting implementation of the tool across the group. The tool had not been completed in relation to Church View Practice at the time of our inspection on 8 April 2021. We were provided with a copy of the proposed template document. We found it had been developed with reference to best practice guidance issued by the Department of Health on infection prevention and control in primary care settings.

## 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
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection we found that one salaried GP was employed permanently by the provider to work at Church View Practice, to oversee and manage the care of approximately 5,905 patients. The practice held a vacant position for one salaried GP and was in the process of recruiting a prescribing pharmacist to replace one staff member who was due to leave their employment.</p> <p>At our inspection on 8 April 2021 we found that the practice had recruited a pharmacist since our previous inspection. The practice had not been successful in recruiting a second salaried GP and continued to seek to fill this vacant post. However, we noted that the salaried GP was supported by an advanced nurse practitioner who worked within the practice on a full-time basis. The practice manager told us that they also employed two locum GPs who provided regular support to the practice and had done so on a long-term basis. The clinical team was further enhanced by the support of the prescribing pharmacist.</p> <p>At our previous inspection we reviewed the training records of six members of staff and found that two (non-clinical) members of staff were not up to date with basic life support training. An assessment of the risks associated with that lack of training had not been carried out. Records showed that four clinical members of staff had completed online basic life support training. However, those staff were not up to date with the practical elements of basic life support training.</p> <p>At our inspection on 8 April 2021 we reviewed the training records of all staff within the practice. We found that staff had completed all required basic life support training. We noted that one staff member who had been very recently recruited to the practice had completed online basic life support training only. However, their practical training had been booked to be completed in June 2021.</p>	

## Appropriate and safe use of medicines

### The practice had systems for the appropriate and safe use of medicines.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	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.	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
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection we found that the practice did not have all emergency medicines that were required to be kept for use in an emergency. For example, dexamethasone oral solution for the emergency treatment of children with croup. After our inspection the provider wrote to us with evidence to show that an assessment of the risk of not keeping the emergency medicine dexamethasone had been carried out in September 2020 and mitigated this risk. This had not been shared with CQC during the inspection. At our inspection on 8 April 2021 we reviewed emergency medicines held by the practice. We found that all required emergency medicines were available to staff, including a supply of dexamethasone oral solution. Systems were in place to monitor stock levels and expiry dates of emergency medicines.</p> <p>At our inspection on 6 November 2020 we reviewed arrangements for the safe storage and use of medicines within the practice. Our review of fridge temperature monitoring records found the temperature of the designated medicines refrigerator had been recorded as being outside of the acceptable temperature limits of between two and eight degrees centigrade on 5 October 2020 (22.5 degrees centigrade) and 20 October 2020 (12 degrees centigrade). However, there were no records to demonstrate that staff had taken action to help establish if medicines stored in the designated refrigerator were still safe to use. Following our inspection, the provider wrote to us with evidence to confirm that they had referred to the manufacturers of the medicines contained within the designated medicine refrigerator. The manufacturers had advised that the deviation in storage temperatures had not compromised the medicines and that they were safe to use.</p> <p>At our inspection on 8 April 2021 we reviewed fridge temperature monitoring records and found that all recorded temperatures were within the required range. The practice used a digital data logger to record and monitor temperatures. The collected data was reviewed on a daily rota basis by designated staff. There was written guidance for staff to follow when the temperature of designated medicine refrigerators was recorded as being outside of acceptable limits. For example, the vaccine management and cold chain standards document.</p>	

## Medicines management

Y/N/Partial

We reviewed the arrangements for the storage and security of designated medicines refrigerators. The designated refrigerators were stored within a locked room and refrigerators were locked when not in use. Stocks of medicines were stored appropriately. We reviewed a random sample of medicines stored within the refrigerators and found all were in date.

At our previous inspection we looked at seven Patient Group Directions (PGDs) and found that four had been completed incorrectly. For example, four of the PGDs had been signed by the nurse after being signed by the GP. The nurse had not therefore been authorised by the GP to use the PGDs to administer medicines to patients. Furthermore, we could not be assured that the GP was aware of which staff were using the PGDs and whether they had the appropriate training to do so at the time of signing.

At this inspection we reviewed eight PGDs, including the four which had previously been completed incorrectly. We found that all PGDs had been reviewed by the GP since our last inspection and resigned, following signature by the nurse. All PGDs we reviewed were valid and had been completed correctly.

As part of this inspection, we completed clinical searches on the practice's patient record system on 30 March 2021. We reviewed a sample of records in order to confirm that patients had undergone the required health monitoring or clinical review prior to prescribing their medicines. The clinical searches undertaken at this inspection identified a small number of minor issues which the provider resolved at the time of inspection. We found insufficient monitoring of a very small number of patients who were prescribed high-risk medicines, including medicines used in the treatment of mood disorders and prevention of stroke. Prescribing was not in line with medicines and healthcare products regulatory agency safety alerts for one patient only.

## Well-led

Rating: No rating given

### 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
Explanation of any answers and additional evidence:  At our previous inspection we found that clinical leadership, including clinical supervision, arrangements at Church View Practice were not clearly defined. Staff were unclear about clinical leadership arrangements in the absence of the local clinical lead salaried GP, who was present in the practice for four days per week.  At our inspection on 8 April 2021 we found that the provider had taken steps to establish and provide clarity with regard to leadership roles within Church View Practice and across the group of practices. We reviewed a standard operating procedure (SOP) document entitled Practice Site Leadership and Site Lead SOP which was on display within the practice. The document provided clear guidance to staff on named persons responsible for clinical leadership and site operations leadership. The document confirmed that the practice's advanced nurse practitioner provided clinical leadership in the absence of the clinical lead salaried GP, with the support of the group medical director. The document also provided information on governance, leadership and supervision arrangements across other practices within the group in order that support could be obtained across the group if required.  Staff within Church View Practice told us they were well supported by the central management team of DMC Healthcare Limited who attended the practice regularly. Staff told us the Registered Manager, who was legally responsible for the day to day delivery of regulated activities at Church View Practice, attended the practice once a week. On the day of our unannounced site visit on 8 April 2021, we noted that the head of nursing was present within the practice in order to provide support to practice staff in implementing newly developed infection prevention and control processes.	

### 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 systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes

Explanation of any answers and additional evidence:

At our previous inspection we looked at the personnel records of six members of staff. Records showed that all six had received an appraisal. However, three of the appraisal records were not dated so we could not be sure when they had taken place. After our inspection the provider wrote to us with evidence which demonstrated that the three appraisals which were not dated had been carried out within the last 12 months. At our inspection on 8 April 2021 we found that no further appraisals had taken place since our last inspection as they were not yet due to be scheduled.

On 6 November 2020 we found that five clinical audits had been carried within the previous 12 months. Only one of the five clinical audits had been repeated to complete the cycle of clinical audit. At our inspection on 8 April 2021, we found that two further clinical audits had been repeated since our last inspection to complete the cycle of clinical audit and demonstrate improvement. In addition, action plans had been implemented for the two clinical audits identified as not being in place at our previous inspection. Our review of documents confirmed that the practice group had in place a clinical audit policy. There was an audit oversight group which met monthly to discuss and review audit activity across the group. We reviewed the minutes of a meeting held on 26 January 2021 and saw that completed audits and proposed audits were discussed and resulting actions clearly recorded.

At our previous inspection we found the practice was unable to demonstrate that processes and systems were effective in the management of risk. At our inspection on 8 April 2021 we found that improvements had been made in managing and mitigating risks. The practice had taken appropriate action to respond to the concerns identified at our previous inspection: staff were up to date with essential training; all required emergency medicines were now held within the practice; authorisations to allow staff to administer medicines were safely managed; there were improved processes for the management of medicines that required refrigeration. The management of infection prevention and control processes had been improved. However, the development of enhanced auditing processes planned by the provider had not yet been fully implemented.

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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

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

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

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

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

## Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- **\*PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#) ).
- $\%$  = per thousand.