

Care Quality Commission

Inspection Evidence Table

Park View Surgery (1-10178239555)

Inspection date: 13 and 14 June 2022

Date of data download: 06 June 2022

Overall rating: Outstanding

We inspected the practice on 20 August 2019 following our annual review of the information available to us and rated the practice requires improvement overall. We rated the practice as requires improvement for the delivery of well-led services because the leadership, governance and culture did not always support the delivery of high-quality person-centered care. Good for responsive services and we did not rate the practice for effective, due to limited evidence available to the Commission relating to this provider to make a judgement.

The provider of this practice changed in May 2021 and inherited the previous inspection rating. We followed up the enforcement action with an announced comprehensive inspection on 12 October 2021. We found that the practice had made some improvements in relation to the breaches in regulation including clinical audits and fire risk assessments. However, there was still no embedded process for significant events. We also identified other areas of concern as not all staff had completed mandatory training, there was no embedded process for complaints and the practice's systems for the appropriate and safe use of medicines and the management of medicine safety alerts required review. The practice was rated as good overall, requires improvement for the safe key question. It was rated as good for the provision of effective and well led services and outstanding for caring and responsive services.

We inspected in June 2022 and saw the practice had made improvements and is now rated Good. We carried forward the ratings from the last inspection of outstanding for caring and responsive.

Safe

Rating: Good

We inspected in October 2021 and rated the practice as requires improvement as not all staff had completed mandatory training, the practice's system for the appropriate and safe use of medicines required review, there was no embedded process for significant events and the management of medicine safety alerts required review.

At this inspection in June 2022, we found improvements had been made. For example all non-clinical staff had received a DBS (disclosure and barring) check, the majority of mandatory training had been

completed, clinical audits had been completed to address concerns for the safe use of medicines and there was a system for safety alerts.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	P
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 the inspection in October 2021 we found:</p> <ul style="list-style-type: none"> Four non-clinical members of staff had not had a DBS check. Although non-clinical staff do not act as chaperones the practice were in the process of obtaining DBS checks for those staff. All staff were up to date with safeguarding training and at the appropriate level. <p>At the inspection in June 2022 we found:</p> <ul style="list-style-type: none"> All non-clinical staff had received a DBS check. <p>In addition we found:</p> <ul style="list-style-type: none"> A Female Genital Mutilation policy was in place and being edited for local use. There were systems to identify vulnerable children on record, but no alerts or codes on parent's records. There was also no coding system for when a child turned 18. The practice agreed to implement a system immediately and this was included in their action plan submitted prior to the site visit. Due to the size of the practice. there were no formal multi-disciplinary meetings to discuss vulnerable children. However, they were discussed at clinical meetings and the GP had regular access with health and social care professionals. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	P
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y

Explanation of any answers and additional evidence:
<ul style="list-style-type: none"> We reviewed staff files and found the practice had not obtained written references for one clinical employee. This is not in line with the practices recruitment and selection policy. They confirmed they had received a verbal reference and submitted references after the site visit.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: August 2021	Y
There was a fire procedure. Date of fire risk assessment: December 2021	Y
Actions from fire risk assessment were identified and completed.	Y

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: June 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: At the inspection in October 2021 we found: <ul style="list-style-type: none"> Two out of five non-clinical staff had not completed infection prevention and control (IPC) training. The practice were aware there were gaps in mandatory training prior to inspection. The practice were trying to encourage uptake by setting aside time and paying for staff's time or arranging lunch for the staff. Mandatory training was part of the practices action plan (submitted at the site visit), due to be completed in October 2021. At the inspection in June 2022, we found: <ul style="list-style-type: none"> One non-clinical staff member had not completed IPC training. The practice confirmed this would be completed within the next two weeks. 	

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

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.	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

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.90	0.82	0.79	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). (01/04/2021 to 31/03/2022) (NHSBSA)	3.9%	6.3%	8.8%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and	4.89	5.30	5.29	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
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)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	78.6‰	162.2‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.26	0.37	0.60	Variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	4.6‰	3.8‰	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.	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.	P
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.	P
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	NA
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	NA
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.	NA

Medicines management	Y/N/Partial
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:</p> <p>As part of our inspection, in October 2021, we undertook a remote search of the practice's clinical records system to assess the quality of care provided by the practice.</p> <ul style="list-style-type: none"> • We reviewed medicine usage of asthma inhalers. Nine patients had been prescribed inhalers in the last 12 months. Of five patient records reviewed four patients had not received a review. We discussed this with the practice, and they agreed inhaler usage would be scrutinised through reviews and six-monthly audits and actioned within three months. This was included in the practices action plan, presented at the site visit. • We also undertook a review of patients prescribed a high-risk drug (used as a blood thinner). 17 patients had been prescribed the medication. Of the five patient records we reviewed, we saw three patients had not been informed of the potential risk and five patients had not received appropriate monitoring tests. We discussed this with the practice, and they shared an action plan on the day of the site visit, which included inviting patients for a review within the next three months. After the inspection the practice confirmed the tests had been completed and seven patients were booked appointments for blood tests. • There was evidence of oversight of prescribing and monitoring of patients' health in relation to the use of Disease Modifying Antirheumatic Drugs (DMARD) which are used to treat inflammatory conditions. Four patients were prescribed the medication. We reviewed two records and saw patients had been monitored appropriately. One patient record didn't have an alert and the practice agreed to add the alert, run searches and ensure clarity regarding shared care agreements and blood monitoring if patients received this via secondary care. This was included in the practices action plan, presented on the site visit. <p>At this inspection in June 2022 we completed a remote search of the practice's clinical records system to assess the quality of care provided by the practice and we also reviewed three clinical audits to address previous concerns regarding asthma inhalers, patients who are prescribed a high-risk drug (used as a blood thinner) and a creatinine clearance (this is a calculation done using the kidney blood test and patient weight and age), audit:</p> <ul style="list-style-type: none"> • Following the inspection in October 2021 the practice had completed an audit of Saba (asthma) inhaler usage. The audit showed a significant increase in the number of patients with an asthma review and action care plan in the last 12 months from 49% in October 2021 to 64%. Searches on the provider's clinical system and from the medical records we reviewed showed patients with asthma had generally received a comprehensive review. We reviewed five patient records and one patient had not received a review. The provider had plans in place to review. • We also undertook a review of patients prescribed a high-risk drug (anti-rheumatic medication) 12 patients had been prescribed the medication. Of the five records reviewed, three patients had 	

Medicines management	Y/N/Partial
<p>not received a medication review and two had not attended a review despite the practice's reminders. The practice confirmed in their action plan they would run monthly searches to mitigate any risk and complete the reviews.</p> <ul style="list-style-type: none"> The practice had completed a creatinine clearance (this is a calculation done using the kidney blood test and patient weight and age), audit to address concerns from the previous inspection regarding a high risk drug used as a blood thinner. The audit showed the percentage of patients with calculated creatinine clearance was 100% in June 2022. We undertook a review of patients prescribed Disease Modifying Antirheumatic Drugs (DMARD) which are used to treat inflammatory conditions. We saw the monitoring of blood tests results needed review. We discussed this with the practice, and they shared an action plan the day before the site visit. 	

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:	12
Number of events that required action:	7
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in October 2021 we found:</p> <ul style="list-style-type: none"> There was still a lack of oversight and documenting of significant events. The practice reported three significant events but were aware there had been more that had not been recorded. Staff provided examples of significant events and the learning, but these were not always documented. Learning from one verbal complaint we saw was to document the issue as a significant event, but there was no evidence of this. The practice were aware this was an issue prior to inspection and were keen to be proactive in documenting and embedding significant event analysis at the practice. This was included in their action plan (presented at the site visit). <p>At the June 2022 inspection, we found:</p> <ul style="list-style-type: none"> There was a system in place to record and monitor significant events including actions and learning. These were discussed at clinical meetings and staff provided examples of incidents and learning. 	

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

Event	Specific action taken
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Patient contact details	Further staff training identified.
Incorrect patient identification	Alert changed and staff to confirm patients date of birth.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in October 2021, we found:</p> <ul style="list-style-type: none"> As part of our inspection, we undertook a remote search of the practice's clinical records system to review the management of combination drug safety alerts, we found the practice did not routinely check historical alerts. We reviewed records of patients prescribed two medicines the alert recommended should not be prescribed together. Of the three patients records we reviewed, three had not been informed of the potential risk or received a review. Guidance states patients should be reviewed every six months. We discussed this with the practice, and they shared an action plan, which included inviting patients for a review, adding six monthly alerts to patients records and to audit every three months. Although the practice took safety alerts seriously, a further review of drug safety alerts was required to ensure all historic safety alerts had been acted on and to ensure future safety alerts were managed in a timely way. <p>At the inspection in June 2022, we found:</p> <ul style="list-style-type: none"> There was a system for acting on safety alerts when they were received. However, there was no rolling process to review historic medicines alerts. For example we saw one patient had been prescribed two medicines the alert recommended should not be prescribed together. The provider reviewed and acted on these immediately following the inspection. 	

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.

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.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	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:	

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. We reviewed four patients records and saw documentation around patients' preferences, for example communication was not recorded and in one record other medical problems were not reviewed. The practice agreed to update the proforma within one month.
- 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

- Clinical searches on the provider's system and from the medical records we reviewed showed patients with asthma had generally received a comprehensive review. However, we reviewed five records and four patients with Asthma who have had two or more courses of rescue steroids in the last 12 months had not received a review after one week. The practice agreed to review all ten patients.
- Medication reviews were carried out on patients with chronic kidney disease. Of the five records we reviewed, four had the medication review code added to their record when only one drug had been reviewed. A clinical search identified two patients who may have a missed potential diagnosis of diabetes from blood tests. The provider confirmed these had all been reviewed and action taken immediately following the inspection.
- 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)	23	23	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received	21	21	100.0%	Met 95% WHO based target

Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
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)	20	21	95.2%	Met 95% WHO based target
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)	20	21	95.2%	Met 95% WHO based target
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)	29	29	100.0%	Met 95% WHO based target

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

Any additional evidence or comments

The practice continued to meet performance target's during the covid pandemic. At the inspection in October 2021, we saw the practice had designed an annual plan to achieve patient outcomes and performance targets for disease management, such as childhood vaccinations and cervical screening. The plan detailed how many appointments and staff were needed per week and year to meet the performance targets. This included staff annual leave and sickness. This enabled the practice to effectively plan the appropriate appointments for patients. The practice aimed to offer 75 appointments per week for every 1000 patients registered with the practice. In addition, the practice also had capacity for emergency, triage and same day face to face appointments. The practice had seen an increase of 120 patients registered with the practice within the last year, including an increase in babies and demand for immunisations. As a result, more appointments were made available to meet the needs of patient demand.

At the inspection in October 2021, the practice had met the 90% target on four out of the five indicators. At this inspection they had achieved the 95% in all indicators and had exceeded in three indicators, achieving 100%.

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	79.6%	N/A	80% Target	Below 80% target

64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	70.6%	62.3%	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)	70.4%	67.5%	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)	30.8%	48.4%	55.4%	No statistical variation

Any additional evidence or comments

The practice told us they proactively book patients for appointments and always ensure there are enough appointments. They have recruited an additional nurse to support the cervical screening programme. They also promoted the importance of cervical screening on social media and via text messages.

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

At the inspection in October 2021 we found:

- We saw evidence of three one cycle audits. The practice confirmed they would engage in more detailed audits about creatinine clearance calculation (this is a calculation done using the kidney blood test and patient weight and age), inhalers and blood tests for certain drug combinations. This will tie in well with the highlighted omissions in the clinical searches carried out as part of this inspection. The three audits were included in the practices action plan (presented at the site visit).

At the inspection in June 2022, we found:

- The practice had completed three clinical audits to address the shortfalls in the clinical searches from the previous inspection and improvements had been made.
- An audit of asthmatic patient reviews and an increased number of SABA inhaler issues had been completed. This showed a progressive improvement of asthma reviews in the last 12 months Asthma from 49% to 64%. The practice confirmed the reviews were ongoing.
- The practice had completed an audit of patients who are prescribed a high risk drug used as a blood thinner and were required to have a creatinine clearance calculation. The audit showed the percentage of patients with calculated creatinine clearance was 100% in June 2022.
- The practice had also completed an audit to ensure appropriate blood tests had been completed for patients on certain drug combinations. The results showed 78% of patients had received blood tests in the past six months compared to 40% in October 2021. In addition 100% of patients on the combination medication had received a medication review in the last 12 months.

Any additional evidence or comments

- As part of an eight practice Primary Care Networks (PCN) there was constant benchmarking. Prescribing was scrutinised regularly with the support of the pharmacist.

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 the inspection in October 2021 we found:

- All staff were up to date with safeguarding training and to the appropriate level. However, there were gaps in other areas of mandatory training for mainly non-clinical staff, such as equality and diversity (six staff both clinical and non-clinical), conflict resolution (four staff both clinical and non-clinical) and infection prevention and control (two non-clinical staff). The practice were aware there were gaps in mandatory training prior to the inspection. The practice were trying to encourage uptake by setting aside time/paying for staff's time or arranging lunch for the staff. Mandatory training was part of the practices action plan (submitted at the site visit), due to be completed in October 2021. All training was reviewed at staff's annual appraisals.
- Staff confirmed they received regular supervisions, clinical peer support and annual appraisals. Appraisals and supervisions were conducted by the lead GP which provided governance oversight. They also mentored the pharmacist and had a close working relationship with them.
- Nurses were allocated time each day to discuss queries, guidance and learning. Staff told us they felt very supported. The staff survey in October 2021 showed 80% of staff felt supported during the pandemic and 20% of staff were satisfied with the support.
- The practice were part of the North primary care network and had access to a clinical pharmacist, a pharmacy technician, four care coordinators, a podiatrist and a dietician. The practice had a system in place to demonstrate the competence of staff employed in advanced clinical practice.

At this inspection, we found:

- The staff uptake of mandatory training had improved significantly. There were minor gaps in equality and diversity training (two staff not completed), and in IPC (one staff member not completed). The practice confirmed this would be completed in the next two weeks.
- Staff had discussions around their competency, but this was not formally documented. The practice agreed to formalise this and review quarterly.

Coordinating care and treatment

Staff worked 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-centered care when they moved between services.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• The frailty lead nurse arranged for patients and liaised with a geriatrician for domiciliary visits if required.• The practice held monthly palliative care meetings with other voluntary organisations to discuss each patient's needs, including any patients who had recently received care from these services.	

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

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.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">As part of our inspection, we reviewed five completed DNACPR decision forms. In all five records, staff had recorded a clear rationale for the decision that was not discriminatory or based on assumptions about the person's quality of life. There was a clear record of a discussion taking place with the person and/or their family and there had been an assessment or decision made about their mental capacity.	

Well-led

Rating: Good

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
<p>Explanation of any answers and additional evidence:</p> <p>Staff told us they felt very supported and management were approachable, and they worked well together as a team. The practice had also completed a staff survey, this showed staff were happy or satisfied.</p> <ul style="list-style-type: none"> The practice had been through a challenging period, they had inherited the previous inspection rating (in August 2019), governance systems, financial issues and staff were reducing their hours due to progression towards retirement. The practice had also seen an increase of 120 patients registered with the practice within the last year, including an increase in babies and demand for immunisations. As a result, more appointments were made available to meet the needs of patient demand. The practice had focused on access and patient care, they were open, honest and aware of the challenges and were keen and proactive to improve. They had made changes, such as practice website, increased the number of telephone lines and a queuing system, introduced a dermatology clinic, implemented an annual plan to meet QOF performance targets, developed a business plan, conducted a staff survey, implemented new clinical policies, arranged regular meetings and appraisals. In addition, they had implemented an action plan for improvement to improve systems and monitoring oversight, such as medicines management, safeguarding, etc. A succession plan was in place and the GP had support from a long-term locum and a neighboring practice to allow for continuity, recruitment plans were in place for a GP, nurse and receptionist and plans were in place for when the practice manager retired. 	

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> <ul style="list-style-type: none"> The practice had a mission statement on their website, which said 'We aim to provide effective and efficient primary care services to our patients, recognising and responding to people's needs in a friendly and approachable way and to promote a healthy, happy and rewarding environment for all the healthcare team'. This was shared with staff for their contribution. Staff said they were involved in discussions leading up to the strategic planning. 	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behavior 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.	P
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in October 2021, we found:</p> <ul style="list-style-type: none"> Although the practice had processes in place to learn from significant events and complaints, we identified not all significant events or complaints were formally documented. The practice were aware prior to the inspection of the shortfalls in the oversight of documenting and monitoring and had an action plan in place to address these areas. Six (out of eight) members of staff had not completed equality and diversity training. The practice were aware of this and confirmed the training was scheduled for November 2021. Staff told us managers and senior clinicians were approachable, and staff felt comfortable in raising any concerns to them. The practice had completed a staff survey in October 2021. 90% of staff said they had a good work life balance, 10% said they were satisfied. <p>At the inspection in June 2022, we found:</p> <ul style="list-style-type: none"> The practice had a system in place to document and monitor significant events and complaints. The majority of staff had completed mandatory training. Two (out of nine) members of staff had not completed equality and diversity training. The practice confirmed this would be completed within two weeks. 	

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

Source	Feedback
Staff spoke very positively about working at the practice. They all said they worked well as a team and felt supported.	

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: <ul style="list-style-type: none">Governance systems were reviewed during staff's annual appraisals and at team meetings.Staff were clear about their role and how to access support.	

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 the inspection in October 2021, we found: <ul style="list-style-type: none">There was a fire risk assessment in place.We saw evidence of three one cycle audits. As a result of the clinical searches, the practice confirmed they would engage in more detailed audits about creatinine clearance calculation (this is a calculation done using the kidney blood test and patient weight and age), asthma inhalers and blood tests for certain drug combinations. The audits were included in the practices action plan (presented at the site visit), with a plan to re-audit.A major incident plan was in place and staff had received training in preparation of major incidents.As part of a primary care network there was constant benchmarking with the CCG. Prescribing was scrutinised regularly with regular involvement from the pharmacist.Regular staff meetings were held within each staff group to discuss any risks, issues or barriers to performance.Although the practice had processes in place to manage and mitigate risks, we identified some risks during our inspection, such as effective management of medicines, that had not been identified or mitigated by the practice. The practice were aware prior to the inspection of shortfalls	

in the oversight of monitoring significant events, complaints and gaps in training and had an action plan in place to address these areas. The action plan also included medicines management.

At the inspection in June 2022, we found:

- The practice had made improvements since the last inspection, for example a system was in place to monitor incidents, complaints, safety alerts and staff mandatory training levels had significantly improved, and they had completed three clinical audits to address shortfalls in the clinical searches we undertook. We identified some risks during our inspection, such as effective management of medicines. The practice had an action plan to address these issues.

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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Throughout the pandemic, the practice continued to provide appointments to patients, through a combination of face-to-face, online and telephone consultations. Where a face-to-face appointment was most appropriate for the patient's condition or individual needs, the practice continued to offer these services daily. Reserved appointment slots were allocated for children to review prior to the end of the working day. The practice had an open appointment policy, whereby all patients would receive a same day appointment. 	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">The practice told us they were familiar with notifications they have to submit to the CQC regarding changes, events and incidents.	

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.	N
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: At the inspection in October 2021, we found: <ul style="list-style-type: none">The practice paused patient participation group (PPG) meetings during the pandemic and were in the process of resurrecting the group and encouraging new members to join to represent the different population groups. The PPG is promoted on the practice website and at the practice. At the inspection in June 2022, we found: <ul style="list-style-type: none">The practice were working with their Primary Care Network (PCN) care coordinator on an action plan to recruit PPG members and hoped to be active within six months.	

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.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: At the inspection in October 2021 we found: <ul style="list-style-type: none">Staff were supported and encouraged to report issues and concerns to managers, and any learnings were disseminated to staff through team meetings. The practice were aware prior to the inspection of shortfalls in the oversight of monitoring significant events and an action plan was in place to improve oversight.The practice were committed to improving services for patients. They were aware of challenges and shortfalls and had a programme of audit in place to improve quality of care.Nurses were allocated time each day to discuss queries, guidance and learning with the lead GP. At the inspection in June 2022, we found: <ul style="list-style-type: none">The practice had a system to monitor significant events and complaints.	

Examples of continuous learning and improvement

The practice had designed an annual plan to achieve patient outcomes and performance targets for disease management, such as childhood vaccinations and cervical screening. The plan detailed how many appointments and staff were needed per week and year to meet the performance targets. This included staff annual leave and sickness. This enabled the practice to effectively plan the appropriate appointments for patients. The practice aimed to offer 75 appointments per week per 1000 patients. In addition, the practice also had capacity for emergency and same day face to face appointments.

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.