

## Inspection Evidence Table

Trent Valley Surgery

(1-7350766532)

**Inspection Date: 11 July 2023**

Date of data download: 26/06/2023

## Overall rating: Requires Improvement

At this inspection, we found that those areas previously regarded as inadequate practice were improved. Further improvements are required, the practice therefore remains rated as requires improvement.

### Safe

### Rating: Requires Improvement

At the last inspection in September 2022 we rated the practice as inadequate for providing safe services because:

Mandatory training had not been completed; processes relating to safeguarding; recruitment of staff; management of infection prevention and control; management of patient risk; fire safety; medicine safety; management of safety alerts and learning lessons were not effective or not implemented.

The data and evidence we reviewed in relation to the safe key question as part of this inspection on 11 July 2023 suggested that those areas previously regarded as inadequate practice had improved but further development in some areas was identified. This practice is therefore now rated as requires improvement for providing safe services.

#### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y

There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in 2022 we found the practice did not operate an effective system to enable proactive monitoring of safeguarding registers. During our inspection in July 2023 we found this had improved.</p> <p>We saw evidence of meetings and discussions taking place regularly with other professionals to support and protect adults and children at risk of significant harm. These meetings have also allowed the provider to update and maintain their safeguarding register to align with the information held by the local authority.</p> <p>The practice had safeguarding policies including a separate policy dealing specifically with female genital mutilation (FGM) in place. Staff we spoke with were aware of their role in safeguarding and how to respond to concerns.</p> <p>A safeguarding alert was available on the practices' clinical system to alert staff easily of concerns. At our previous inspection in September 2022 we found not all family members of children with a safeguarding concern were correctly coded to ensure easy identification. During our current inspection we found this had improved but a further review would ensure that all families had been correctly coded. The lead GP was aware of all the families who were included on the practices safeguarding register and discussed them with the GP Specialist Advisor</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in September 2022 the practice did not have systems in place to ensure safe recruitment had been undertaken and appropriate vaccination records were not in place.</p>	

During our current inspection we reviewed 4 recruitment files, all were well kept and had appropriate recruitment documentation and vaccination records in place.

The provider had staff not directly employed by them who attended the practice to deliver care for patients. We saw appropriate recruitment information from their employers was held at the practice and a memorandum of understanding in place between the employers of these staff and the practice. This provided the practice with assurance of safe recruitment and set out a clear understanding of responsibilities.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: November 2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: November 2022	Y
Actions from fire risk assessment were identified and completed.	Y
Data sheets relating to the control of substances potentially hazardous to health (COSHH) were in place. Both the provider and the external cleaning company had separate data sheets that did not match. Some were kept appropriately with the substances others were kept in an office and not readily available to staff if required.	

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met/not met.**

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: Trent Valley Surgery June 2023 Torksey Branch April 2023	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
All staff had undertaken infection prevention and control (IP&C) training within the last 12 months as required by the providers training schedule.	
Action plans were in place in relation to issues identified on the latest infection prevention and control audits at the practice. Some actions were ongoing due to the need for negotiation with	

the branch sites landlord and replacement of equipment was subject to a rolling monthly purchase plan. For example, one patient couch was being purchased each month.

The practice was visibly clean, uncluttered and tidy. Cleaning of the practice was completed by an external contractor. We saw cleaning schedules in place for daily, weekly and monthly tasks for both clinical and non-clinical areas. There were multiple different versions of cleaning check sheets in use. These were not completed consistently by staff.

The practice manager carried out a monthly check of the premises for cleanliness, this identified any issues and required actions. On review of consecutive checklists it was documented that highlighted concerns had been actioned.

A carpet was fitted in a clinical room at the branch site, that was visibly clean, and a cleaning schedule was in place to deep clean this twice a year.

### Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
Explanation of any answers and additional evidence:  Staff told us that there was a shortage of administrative and dispensary staff. On the day of our inspection we saw evidence that 2 new administrative staff had started work and adverts to continue recruiting to the dispensary remained open. Adjustments to the times when patients were able to collect medicines from the dispensary ensured that sufficient staff were in place.  All staff had received training in medical emergencies or sepsis appropriate for their role. This included clinical and non-clinical staff.	

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	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
The provider had a system for the summarising of new patient notes. Data provided to us from 31 May 2023 showed 145 (3.4% of the patient list) new patient notes were waiting to be summarised. Historic paper notes were available on site to view if required. We reviewed the provider's action plan to resolve the situation which appeared to be realistic.	

**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	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	1.06	1.16	0.91	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). (01/04/2022 to 31/03/2023) (NHSBSA)	9.6%	10.9%	7.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed	5.52	5.34	5.23	No statistical variation

for uncomplicated urinary tract infection (01/10/2022 to 31/03/2023) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	273.3‰	223.0‰	129.8‰	Tending towards variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.63	0.77	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	12.2‰	8.5‰	6.8‰	Tending towards variation (negative)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Partial
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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y

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>The provider had audited the prescribing competence of non-medical prescribers employed by the practice and the audits were repeated at 4 monthly intervals.</p> <p>There was a process for the handling of requests for repeat medicines and evidence of medicines reviews for patients on repeat medicines. During our clinical searches we saw medicine reviews conducted did not always include comprehensive documenting of outcomes or address the required monitoring or changes to treatment that should have been identified.</p> <p>Data we reviewed showed the practice prescribed medications that could be addictive to patients at a higher rate than the local and national average. This was slightly improved since our previous inspection in September 2022. The provider had carried out a review to assess prescribing patterns and made changes as appropriate, it was highlighted the higher prescribing rates were due to the patient demographic.</p>	

<b>Dispensary services (where the practice provided a dispensary service)</b>	<b>Y/N/Partial</b>
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable	Y



for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Y
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y

### 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 since September 2022:	7
Number of events that required action:	7
<p>Explanation of any answers and additional evidence:</p> <p>We saw the analysis reports for the 7 significant events since our previous inspection in September 2022. The reports were comprehensive, highlighted issues and appropriate actions to mitigate the chances of reoccurrence.</p>	

Event	Specific action taken
Delay in a patient with a potential cancer getting an appointment to see GP, reception did not send through to on call clinician for review.	Discussed with the reception team and at staff meetings. Call flow chart developed to ensure consistent triage of calls and appropriate clinical allocation. This was reviewed after a month and was working well.
Vaccine storage incident, vaccine fridge out of temperature range due to a power cut at branch site.	Correct cold chain procedures followed vaccine storage check list completed. Vaccine manufacture contacted promptly for guidance



	with regards to vaccines being out of cold chain for 1 hour to assess safety. Advice followed. Due to the event less vaccines are stored at branch site with more frequent deliveries from the main site if required.
Failure to invite a patient for an NHS health check. Recall not added to record. No harm caused.	Discussed at team meetings, audit report created to capture any issues with recall of patients. Seventy five patients were identified, all had since been called for repeat health checks. The report is repeated on a monthly basis.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The system in place for recording and actioning safety alerts was currently under review and a trial was underway to identify the best way to manage these appropriately. We saw examples of actions taken on recent alerts, for example, regarding medicines availability and equipment concerns.</p> <p>The provider was unable to demonstrate that all relevant safety alerts had been responded to in line with the Medicine and Healthcare products Regulatory Agency (MHRA) guidance which left patients at risk of harm.</p> <p>Remote clinical searches identified 16 women took a medicine which may increase the risk of birth defects in patients of childbearing age. We reviewed 5 sets of clinical records and found 4 had no evidence that information related to the potential risks had been given.</p> <p>Clinical searches identified 5 patients who took a diuretic, to reduce the amount of water in the body which may increase the risks of skin cancer if taken over a long period. We reviewed 2 sets of clinical records and found that neither patient had responded to text messages or invitation letters to attend the surgery for a review. The provider had sent written information out to the patients that did not fully cover the risk identified in safety alerts.</p>	

**Effective**

**Rating: Requires Improvement**

At the last inspection in September 2022 we rated the practice as requires improvement for providing effective services because:

The practice was unable to demonstrate that all staff had the skills, knowledge and experience to carry out their roles. Systems and processes relating to people with long term conditions and high risk medications was not always effective.

At this inspection, we found that some areas previously regarded as requiring improvement had improved. Further developments were identified as needed in relation to some aspects. The rating for providing effective services remains unchanged as requires improvement.

*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.	Partial
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
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:  Staff had a triage tool to identify patients most in need of an urgent appointment. Patients submitted feedback to us before our inspection confirming if they needed to be seen due to an urgent problem the staff would ensure they were seen and reviewed that day.	

Medication reviews were undertaken but did not always include enough clinical details or address alerts flagged on the patient record. The provider could not be assured a comprehensive assessment had taken place.

## Effective care for the practice population

### Findings

- 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.
- Patients had access to appropriate health assessments.
- 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 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 clinical searches identified a total of 16 patients taking a medicine which may be used to treat cancer and autoimmune and inflammatory disease. Of these we identified all patients had been monitored appropriately.
- The clinical searches identified a total of 187 patients taking a medicine which may be used to prevent harmful blood clots forming in blood vessels. Of the 187 we identified 2 patients who appeared to be minimally overdue appropriate monitoring. We reviewed both records and found that there were no problems with the care for either patient.

## Management of people with long term conditions

### Findings

- Patients requiring high dose steroid treatment for severe asthma episodes were not always followed up in line with national guidance to ensure they received appropriate care. Clinical searches identified 417 patients on the asthma register. From these it was identified 20 patients had been prescribed 2 or more courses of rescue steroids in the past 12 months. We reviewed 5 records, all of which had received appropriate detailed asthma reviews. When the steroids were issued to 2 the 5 of the patients the clinical status of the patient at that point was not included in the patient records to justify the

decision to prescribe. Three of the 5 patients had not been issued with steroid treatment cards when it was clinically indicated.

- Patients with long term conditions were not always reviewed to ensure their treatment was optimised in line with national guidance. Clinical searches identified 216 patients with hypothyroidism, of which 15 had not undergone blood tests to monitor treatment in the previous 12 months as indicated in national guidance. We saw evidence that the provider had sent text messages to patient requesting they attend for monitoring, but they had not complied. The provider did not have systems in place to ensure medication dosage or quantity issued was reduced to ensure safety when this occurred.
- Clinical searches identified 350 patients with a diagnosis of diabetes. Fourteen patients with diabetic retinopathy had a significantly raised blood sugar result. We reviewed a random sample of 3 records, all had received appropriate treatment.
- All patients with blood tests that indicated a potential diagnosis of diabetes had been identified and care delivered appropriately.
- All patients with chronic kidney disease (CKD) at stages 4 or 5 had been monitored appropriately in line with best practice guidelines.
- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- 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.

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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	24	25	96.0%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	25	26	96.2%	Met 95% WHO based target

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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	24	26	92.3%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	25	26	96.2%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	24	28	85.7%	Below 90% minimum

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

#### Any additional evidence or comments

Staff were aware of the slightly lower than the minimum target for children receiving the MMR immunisations. We saw evidence of staff making efforts to get parents to bring children in for immunisation with repeated calls and ad-hoc requests.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	65.7%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	76.5%	N/A	70.3%	N/A
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). (12/31/2022 to 12/31/2022) (UKHSA)	76.5%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	68.8%	57.9%	54.9%	No statistical variation

### Any additional evidence or comments

Patients who failed to attend for cervical screening had an alert on their records and were encouraged by the nursing teams when they next attended the practice.

### 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:  The practice had completed clinical audit on the prescribing of medication to patient with chronic kidney disease; care given to patients newly diagnosed with hypertension and childhood immunisation uptake. These had resulted in improved outcomes for patients.	

### 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

At our previous inspection staff we spoke with told us they did not have any protected time for learning including the providers' essential training. Following that inspection, the practice had introduced monthly protected learning time and staff we spoke with confirmed it provided the opportunity to complete their training.

Audits had been completed on consultations undertaken by clinicians employed at the practice who provide advanced clinical care to assure the provider of competence and identify any learning needs.

### **Coordinating care and treatment**

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y

### **Helping patients to live healthier lives.**

#### **Staff were 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
Explanation of any answers and additional evidence:	
A monthly multi-disciplinary meeting took place to review patients in the last 12 months of their lives. This included both practice clinician and external stakeholders. A written log of patients and their needs was kept ensuring all staff could access as required.	



### 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, including from clinical searches:  Our clinical review of notes where a DNACPR decision had been recorded, this identified not all recorded information was up to date, a patient's capacity to make decisions had changed and this was not documented correctly. We reviewed 4 records, 2 of which were completed in secondary care, this meant no records were in place to review. The remaining 2 were completed appropriately.	

## Responsive

**Rating: Good**

The data and evidence we reviewed in relation to the responsive key question as part of this inspection did not suggest we needed to review the rating for responsive at this time. Responsive remains rated as good.

### Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

### Practice Opening Times

Opening times: Trent Valley Surgery	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	7:30am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available: Trent Valley Surgery	
Monday	8am to 5.50pm
Tuesday	8am to 5.50pm
Wednesday	7.30am to 5.50pm
Thursday	8am to 5.50pm
Friday	8am to 5.50pm
Appointments available: Torksey Surgery	
Monday	8am to 1.50pm
Tuesday	8am to 1.50pm
Wednesday	8am to 1.50pm
Thursday	8am to 1.50pm
Friday	8am to 1.50pm
<b>Further information about how the practice is responding to the needs of their population</b>	
<p>Patients had a named GP who supported them in whatever setting they lived.</p> <p>The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.</p> <p>There was a medicines delivery service for housebound patients.</p> <p>The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.</p> <p>All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.</p> <p>Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a PCN.</p>	

The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.

The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

## Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence:</p> <p>On the day of inspection appointments were available for the next day and could be prebooked if the need were deemed appropriate. Phlebotomy appointments were available within 3 days.</p> <p>We asked the practice to provide us with details of the number and type of appointments from the GP Appointments Data (GPAD) Dashboard that had been completed by GPs and Advanced Nurse Practitioners (ANPs) in April, May and June 2023.</p> <p>For April 2023 there had been a total of 2894 appointments of which 88% had been face to face consultations.</p> <p>For May 2023 there had been a total of 3608 appointments of which 92% had been face to face consultations.</p> <p>For June 2023 there had been a total of 2941 appointments of which 94% had been face to face consultations.</p> <p>Patients had timely access to appointments. The widely accepted number (as per, for example, The British Journal of General Practice) is between 70 and 72 appointments per 1,000 patients per week. These figures would indicate that for a list size of 4019 one could expect to see around 300 appointments per week Data received covered a 12 week period and the average number of appointments available per week was 726.</p>	

We reviewed telephone call data from June 2023. This showed call wait times ranged from 1 and a half minutes to a maximum of 13 minutes at peak times.

### National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	82.7%	N/A	52.7%	Significant variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	65.5%	59.3%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	63.1%	56.6%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	80.1%	76.3%	71.9%	No statistical variation

Source	Feedback
A home with patient requiring nursing care sourced from Trent Valley Surgery.	The practice is good to work with and communication is easy. The staff are approachable and any requests for review or visits are actioned quickly.

### Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	8

Number of complaints we examined.	6
Number of complaints we examined that were satisfactorily handled in a timely way.	6
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
The provider's complaint log included actions taken and where these along with learning would be discussed. On review of the meeting minutes identified documented discussion relating to the complaints, actions, learning and changes were evidenced.	

Examples of learning from complaints.

Complaint	Specific action taken
Concerns letters were not in record at the time of telephone appointment with GP and as a result was unaware of new diagnosis.	Extra staff have been trained to enable letters to be added to records quicker.
Patient unable to make appointment at the practice and was unhappy about the service they received.	Further training delivered to reception staff on how to book remote appointments for patients.

## Well-led

## Rating: Good

At the last inspection in September 2022 we rated the practice as requires improvement for providing well-led services because:

Leadership and culture within the practice did not effectively manage and support high quality sustainable care, governance arrangements were ineffective and processes for managing risks were not effective.

At this inspection, we found that the majority of those areas previously regarded as requiring improvement had improved.

### 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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Members of the management team were aware of the challenges to quality and sustainability in relation to recruitment, staff shortages and finance. Plans were in place to address these challenges.</p> <p>The practice is run as a partnership with one GP and a non-clinical partner. Therefore, there was no succession plan in place for the GP. The provider had an agreement in place with another local GP to provide short term management cover if required. Meanwhile, recruitment for a GP partner to join the practice continued.</p> <p>Training had been undertaken by members of the management team to develop and support good, effective leadership within the practice. Plans were in place to identify a deputy practice manager.</p>	

### 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

### Culture

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

	Y/N/Partial
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There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We received 11 staff feedback forms and spoke with 5 members of staff during our inspection.</p> <p>The majority of staff members felt well supported by visible and approachable managers. A small minority of staff told us they felt communication could be better.</p> <p>Regular appraisals and one to one meetings had been undertaken for all staff to support wellbeing and identify any individual concerns or needs.</p> <p>The practice had an identified Freedom to Speak Up Guardian (FTSUG), posters were in place to promote this within the staff room.</p>	

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

Source	Feedback
Staff	A good team atmosphere with good team working with a good mix of male and female clinicians and different specialist interests. Changes are made where necessary to improve patient care and experience.
Staff	Trent Valley have given me the opportunity to learn and develop through training appropriate to my role. Team working is good, and staff have come together to offer the best service to our patients
Staff	Excellent Clinicians, Nursing team. Staff generally supportive of each other. Staffing shortages within the dispensary and admin team can impact on work life balance.
Staff	Friendly place to work, but busy and all staff members could be shown more appreciation. Communication within the admin team is not always the best

### Governance arrangements

**There were clear responsibilities, roles and systems of accountability to support good governance and management in the majority of areas. Work was required to continue to develop some systems and processes.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in September 2022 we found significant gaps in relation to good governance at the practice. During our current inspection we saw many areas had improved significantly and management had introduced new systems and processes which had improved safety.</p> <p>Regular governance meetings were undertaken with set agendas to ensure all aspects of good governance were regularly reviewed, discussed and shared with staff.</p> <p>Management of risks had improved they were recorded on a system available to all staff and discussed at governance meetings.</p> <p>Staff training had been completed in line with the practices schedule and legislation. Staff recruitment processes and monitoring of staff vaccinations had improved.</p> <p>Realistic plans were in place to manage the backlog of new patient notes awaiting summarisation and prevent future issues.</p> <p>Management of patients on high risk medicines, management of patients with long term conditions and management of safety alerts had improved but required further development.</p> <p>Safeguarding systems and processes had improved since the previous inspection in September 2022. Coding of families of anyone with a safeguarding concern had improved but required further development. The Safeguarding lead was aware of all safeguarding concerns and their families, but staff would not always be alerted to all concerns.</p>	

### 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
<p>Explanation of any answers and additional evidence:</p> <p>Risks were identified and listed on the IT system to allow monitoring and ease of access for all staff. We saw evidence risks were regularly discussed at meetings within the practice.</p>	

### **Appropriate and accurate information**

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider used data to identify improvements and new ways of working in relation to aspects of the practices' performance. These included, patient flow, types of appointments in place, missed appointments, childhood immunisation uptake and review of complaint themes.</p>	

### **Governance and oversight of remote services**

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y

The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y

### Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Patient and staff views were acted on to improve services, changes had been made to clinics and the way patients displaying inappropriate behaviour were managed.</p> <p>The patient participation group had undertaken an audit of the surroundings, which identified issues and concerns. The provider responded and made the changes to improve the patient experience.</p> <p>Staff views were gathered to develop standards for the administration tasks requiring completion to ensure consistency and safe care.</p>	

### Any additional evidence

We received 11 responses from patients who gave feedback on care, 10 were positive about care received, ability to get an appointment and staff's caring attitude. One comment was left that not being able to book routine appointments in advance was problematic.

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:  Learning from SEA, complaints and compliments were discussed at the regular monthly staff meetings and minutes were available for staff unable to attend.	

### Examples of continuous learning and improvement

The provider had implemented protected learning time on a monthly basis within the practice to allow staff to complete training and attend meetings to improve communication and inclusion.

### 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 practices 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)	≥3
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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.