

Care Quality Commission

Inspection Evidence Table

Elm Surgery (1-542363804)

Inspection date: 28 September 2022

Date of data download: 27 September 2022

Overall rating: Good

The practice was previously inspected and rated good in March 2016. This inspection was a focused inspection of the safe, effective and well-led domains. The provider had maintained their good rating.

Safe

Rating: Good

Safety systems and processes

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

| Safeguarding | Y/N/Partial |
|--|-------------|
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Yes |
| Partners and staff were trained to appropriate levels for their role. | Yes |
| There was active and appropriate engagement in local safeguarding processes. | Yes |
| The Out of Hours service was informed of relevant safeguarding information. | Yes |
| There were systems to identify vulnerable patients on record. | Yes |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Yes |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Yes |

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

| |
|---|
| Explanation of any answers and additional evidence: |
| We reviewed four staff recruitment files and found one gap in the staff vaccination status. After the inspection, the practice provided us with an updated spreadsheet with the vaccination status for all clinical staff in the practice. We were assured that all staff had their vaccination maintained in line with current guidance. |

| Safety systems and records | Y/N/Partial |
|---|-------------|
| Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 30/11/2021 | Yes |
| There was a fire procedure. Date of fire risk assessment: 20/09/2022 | Yes |
| Actions from fire risk assessment were identified and completed. | Yes |

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

| | Y/N/Partial |
|---|-------------|
| Staff had received effective training on infection prevention and control. | Yes |
| Infection prevention and control audits were carried out. Date of last infection prevention and control audit: Checklist completed. Audit completed post inspection (29/09/22) | Partial |
| The practice had acted on any issues identified in infection prevention and control audits. | Partial |
| The arrangements for managing waste and clinical specimens kept people safe. | Yes |
| Explanation of any answers and additional evidence: | |
| At the time of the inspection, there was no infection and prevention control (IPC) audit in place, however, there was a comprehensive IPC checklist completed, that covered all IPC areas in the practice. Whilst the checklist contained whether the practice was or was not maintaining IPC standards it did not contain details of any actions that should be taken. We requested additional evidence to be submitted after the inspection to demonstrate that any potential risk had been considered. The practice provided us with evidence of an audit which was completed the day after our inspection. The audit highlighted areas where actions were required. Where actions were outstanding timescales were attached and a staff member responsible for completing the action. | |
| Seven out of 10 clinical rooms in the practice had carpets in them and there were no risk assessments to define clinical regimes and preventative measures in place. Carpets should be avoided in clinical areas in order to promote the control of infection. The provider told us that although a formal risk assessment had not been documented they had considered the risk. The practice ensured all procedures were carried out in the other three rooms that have medical vinyl flooring. We requested additional evidence to be submitted after the inspection. The practice submitted an IPC risk assessment and control form for carpets in clinical rooms, recognising a strict cleaning schedule. The practice was in process of utilising medical vinyl flooring in all clinical rooms starting in October 2022. | |

Risks to patients

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

| | Y/N/Partial |
|---|-------------|
| There was an effective approach to managing staff absences and busy periods. | Yes |
| There was an effective induction system for temporary staff tailored to their role. | Yes |
| The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures. | Yes |
| Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients. | Yes |
| There were enough staff to provide appointments and prevent staff from working excessive hours | Yes |

Information to deliver safe care and treatment

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

| | Y/N/Partial |
|--|-------------|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. ¹ | Yes |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Yes |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | Yes |
| Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals. | Yes |
| There was a documented approach to the management of test results and this was managed in a timely manner. | Yes |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | Yes |
| Explanation of any answers and additional evidence: Review of patient records in relation to the clinical searches identified that care records were managed in line with current guidance. | |

Appropriate and safe use of medicines

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

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

| Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA) | 1.06 | 0.81 | 0.82 | No statistical variation |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA) | 9.1% | 8.9% | 8.5% | No statistical variation |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA) | 6.06 | 5.74 | 5.31 | No statistical variation |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA) | 191.1‰ | 139.2‰ | 128.0‰ | No statistical variation |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA) | 0.26 | 0.72 | 0.59 | Tending towards variation (positive) |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA) | 13.3‰ | 7.4‰ | 6.8‰ | 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. | Yes |
| Blank prescriptions were kept securely, and their use monitored in line with national guidance. | Yes |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Yes |
| 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. | Partial |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. ¹ | Partial |

| Medicines management | Y/N/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. | Yes |
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. ² | Yes |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | N/A |
| There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer. | N/A |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | N/A |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Yes |
| For remote or online prescribing there were effective protocols for verifying patient identity. | Yes |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Yes |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Yes |
| Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective. | Yes |
| <p data-bbox="57 1202 1541 1247">Explanation of any answers and additional evidence, including from clinical searches.</p> <p data-bbox="57 1281 1541 1471">Since our previous inspection the practice had seen an increase in patient list size following the acquisition of two other local practices. From 6,000 patients in 2016 to over 9,500 patients at the time of the inspection, with significant increase from September 2021 (7,000 patients) to December 2021 (9,500). The practice evidenced that they had prioritised ensuring these patients had received the appropriate monitoring as evidenced by our clinical searches.</p> <p data-bbox="57 1516 1541 1740">The number of unique patients prescribed multiple psychotropics (drugs that have effects on psychological function and include anti-depressive agents, hallucinogens and tranquilizing agents) per 1,000 patients in the practice was higher than England and Clinical Commissioning Group (CCG) averages. We asked the practice to provide additional evidence and explanation for this. After the inspection, the provider sent us an audit of patients on multiple psychotropics. It showed that all of those patients had appropriate monitoring in place.</p> <p data-bbox="57 1785 1541 2013">There were two non-medical prescribers in the practice. (Non-medical prescribing (NMP) is the term used to describe any prescribing completed by a healthcare professional other than a doctor or dentist). During the remote searches, the practice were not able to demonstrate the prescribing competence of non-medical prescribers. For example, by an audit or supervision. We discussed the importance of having regular reviews of non-medical prescribers. This was actioned immediately and at the time of the inspection we saw evidence which showed an audit of prescribing had been completed for both non-</p> | |

| Medicines management | Y/N/Partial |
|---|-------------|
| <p>medical prescribers. The provider told us they have a plan in place for the audit to be completed quarterly.</p> <p>The provider was able to demonstrate that it remained safe to prescribe medicines to patients where specific, frequent monitoring was required. For example, our clinical search of patient records identified 66 patients on Disease-modifying anti-rheumatic drugs (DMARDS), which are high-risk medicines. All 66 patients had appropriate monitoring in place.</p> <p>Our clinical remote search of patient records identified 48 patients with asthma who had received two or more courses of prednisolone (an anti-inflammatory steroid). Not all of them had the required monitoring in place in the last 12 months. This had been fed back to the provider following our searches and was actioned immediately by the practice. At the time of the site visit, which was a week after the searches took place, the provider showed us an audit of the asthma register and 26 out of 48 patients had been reviewed. Where action was needed the patient had been contacted for additional tests or appointments scheduled. The other 22 patients were yet to be reviewed, however the practice had a plan in place to address these remaining patients prioritising by risk as outlined in the audit.</p> | |

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

| Significant events | Y/N/Partial |
|--|-------------|
| The practice monitored and reviewed safety using information from a variety of sources. | Yes |
| Staff knew how to identify and report concerns, safety incidents and near misses. | Yes |
| There was a system for recording and acting on significant events. | Yes |
| Staff understood how to raise concerns and report incidents both internally and externally. | Yes |
| There was evidence of learning and dissemination of information. | Yes |
| Number of events recorded in last 12 months: | 15 |
| Number of events that required action: | 0 |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice kept a log of all the significant events. Each case was reviewed, and actions and learning points were recognised and shared with the team. If there was any further action to be taken these had timescales and were reviewed appropriately.</p> | |

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

| Event | Specific action taken |
|---|--|
| The wrong dose of medication had been prescribed for Fostair Inhaler (a steroid inhaler used both as a preventer and reliever for lung diseases). The dose was increased in the hospital, but the surgery was not informed. | <ul style="list-style-type: none"> A new prescription was issued for the patient. Clinicians were reminded to check the latest correspondence from the hospital to avoid this situation in the future. |

| | |
|---|--|
| Possible General Data Protection Regulation (GDPR) breach, as a text message was sent to the wrong patient. | <ul style="list-style-type: none"> The event was investigated. The mobile phone number was copied from another patient's records and pasted onto the wrong record. All reception staff were informed of the incident and reminded not to copy-paste mobile numbers and to double check records to prevent this from happening again. |
|---|--|

| Safety alerts | Y/N/Partial |
|---|-------------|
| There was a system for recording and acting on safety alerts. ¹ | Yes |
| Staff understood how to deal with alerts. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>The provider was able to demonstrate that all relevant safety alerts had been responded to. Clinical staff we spoke with conformed they were informed of any safety alerts.</p> | |

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. | Yes |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹ | Yes |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ² | Yes |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Yes |
| Patients' treatment was regularly reviewed and updated. ³ | Yes |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Yes |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Yes |
| The practice prioritised care for their most clinically vulnerable patients. | Yes |

Effective care for the practice population

| Findings |
|---|
| <ul style="list-style-type: none">• 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.• All patients over the age of 75 were sent a letter by post informing them of their named GP and were invited for a health check and informed of services available to them, for example, monthly prescriptions.• There was an 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 had a dedicated family planning lead in place, who had the Faculty of Sexual and Reproductive Healthcare (FSRH) accreditation as a trainer.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice was named as a dementia-friendly surgery in 2018.
- There was a childhood immunisation programme and comprehensive monitoring system in place for those who did not attend the appointments. This meant the practice was up to date with all childhood immunisations.
- For children, the practice offered "school-friendly" and "after-school" appointments if required.
- For people experiencing poor mental health, the practice worked with Sound Primary Care Network (PCN). Patients had access to regular mental health reviews with mental health practitioners and counsellor.

Management of people with long term conditions

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicine 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.
- Patients with complex needs had the option available for double appointments, home visits and joined visits with an Advanced Healthcare Professionals.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up with patients who had received treatment in a hospital or through out-of-hours services.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Adults with the newly diagnosed cardiovascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with chronic obstructive pulmonary disease (COPD) were offered annual reviews and rescue packs. Rescue packs are a short course of steroids and antibiotics issued in advance, for a person with COPD to keep at home and use as part of their acute exacerbation plan.
- Patients with asthma were offered an asthma management plan.
- The practice had a dedicated Quality of Framework (QoF) lead in place, who monitored outcomes for patients.

| 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) | 56 | 58 | 96.6% | Met 95% WHO based target |

| | | | | |
|---|----|----|--------|--------------------------|
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 68 | 69 | 98.6% | 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) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 69 | 69 | 100.0% | 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) | 68 | 69 | 98.6% | 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) | 63 | 64 | 98.4% | 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>

| Cancer Indicators | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency) | 77.5% | N/A | 80% Target | Below 80% target |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA) | 77.5% | 66.5% | 61.3% | N/A |
| Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA) | 74.3% | 71.4% | 66.8% | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA) | 56.3% | 56.6% | 55.4% | No statistical variation |

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

Any additional evidence or comments

The practice did not meet the 80% England average for cervical cancer screening. We saw evidence of unverified data from the practice, which suggested that the practice's cervical screening was at 79.5% (78% for people aged 25-49 and 81% for people aged 50-64).

We saw evidence the practice encouraged uptake by inviting eligible patients, displaying posters in the practice and monitoring the progress closely. Recently the practice had also introduced Saturday clinics.

Monitoring care and treatment

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

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

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

The practice had conducted a 12-monthly audit of patients on unopposed oestrogen. Patients on oestrogen therapy without current progesterone therapy are at risk of endometrial cancer. The initial audit in February 2021 found there were no patients in the practice who were at risk, however, the decision was made to re-audit every 12 months. An updated audit took place in March 2022 and found there were no patients on unopposed oestrogen.

Any additional evidence or comments

The practice is involved in a number of local and national Quality Improvements initiatives. For example:

- Interface-stoma and Continence Support programme, which identifies patients using continence and stoma products and gives the opportunity to access a nurse-led programme.
- Interface Chronic Obstructive Pulmonary Disease (COPD) Review Service, in which the clinical pharmacist supported the practice, in the management of patients with COPD, to reduce the risk and symptoms of exacerbations and referrals to secondary care.

Effective staffing

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

| | Y/N/Partial |
|--|-------------|
| Staff had the skills, knowledge and experience to deliver effective care, support and treatment. | Yes |

| | |
|--|-----|
| The practice had a programme of learning and development. | Yes |
| Staff had protected time for learning and development. | Yes |
| There was an induction programme for new staff. | Yes |
| Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation. | Yes |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | Yes |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Yes |
| Explanation of any answers and additional evidence: | |
| The practice provided GP training and accommodated fifth-year medical students. All partners in the practice are trained to complete assessments. There were three registrars working in the practice at the time of the inspection, which helped with the practice's capacity and supported the doctors in getting their qualifications. | |

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

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

Consent to care and treatment

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

| | Y/N/Partial |
|--|-------------|
| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | Yes |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | Yes |
| Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹ | Yes |
| Explanation of any answers and additional evidence Our clinical review of notes where a DNACPR decision had been recorded identified, where possible, the patients views had been sought and respected. We saw that information had been shared with relevant agencies. | |

Responsive

Rating: Not rated

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. | Yes |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online). | Yes |
| Patients were able to make appointments in a way which met their needs. | Yes |
| There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded). | Yes |
| Patients with most urgent needs had their care and treatment prioritized. | Yes |
| There was information available for patients to support them to understand how to access services (including on websites and telephone messages). | Yes |
| Explanation of any answers and additional evidence: The practice used digital platform for patient triage and communication. They were able to send and receive texts, photographs, video calls and documents. Patients had access to a range of different appointments: face-to-face, telephone calls, video calls and eConsult. The practice offered extended hours every day at 07:30 am for face-to-face healthcare assistant (HCA) and nurse appointments and GP telephone consultations. | |

Well-led

Rating: Good

We rated this key question as good and observed the below areas of outstanding:

- There was an emphasis on patient-centred care, continuous improvement and resilience within the practice. Since the last inspection, the practice faced the challenges of the COVID-19 pandemic and the growing population list (due to two neighbouring GP practices closures). Despite those challenges, the practice continued to provide safe, effective and well-led and provided good outcomes for their patients.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

| | Y/N/Partial |
|--|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Yes |
| They had identified the actions necessary to address these challenges. | Yes |
| Staff reported that leaders were visible and approachable. | Yes |
| There was a leadership development programme, including a succession plan. | Yes |
| Explanation of any answers and additional evidence: | |
| The practice reviewed the needs of their local population regularly and were responding to any issues arising showing their sustainability and resilience. In 2019 and 2021 two nearby practices closed and Elm Surgery registered nearly 2,500 patients. The practice continued to provide safe care and treatment to their patients despite this challenge and throughout the COVID-19 pandemic. | |

Vision and strategy

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

| | Y/N/Partial |
|---|-------------|
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Yes |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Yes |
| Progress against delivery of the strategy was monitored. | Yes |
| Explanation of any answers and additional evidence: | |
| All staff we spoke with were aware of the vision and values of the practice and were passionate about delivering patient-centred care for patients. | |
| The practice had regular Clinical Governance meetings, in which any complaints, significant events, safeguarding issues and new policies and procedures were discussed. Information following those meetings was shared with all staff. Everyone in the practice was well informed about the plans to improve the services. | |

Culture

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

| | Y/N/Partial |
|--|-------------|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | Yes |
| Staff reported that they felt able to raise concerns without fear of retribution. | Yes |
| There was a strong emphasis on the safety and well-being of staff. | Yes |
| There were systems to ensure compliance with the requirements of the duty of candour. | Yes |
| When people were affected by things that went wrong, they were given an apology and informed of any resulting action. | Yes |
| The practice encouraged candour, openness and honesty. | Yes |
| The practice had access to a Freedom to Speak Up Guardian. | Yes |
| Staff had undertaken equality and diversity training. | Yes |
| Explanation of any answers and additional evidence: | |
| <p>The staff we spoke with reported to us that they felt supported and if they had any concerns they had faith in the management and felt confident issues would be acted on and resolved.</p> <p>There was a Freedom to Speak up Guardian in place and all staff reported they knew who it was and how to reach them if they needed it.</p> | |

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

| Source | Feedback |
|-------------------------|---|
| CQC staff Questionnaire | <ul style="list-style-type: none"> We sent staff questionnaires to the practice prior to the inspection. We received seven completed staff surveys before the inspection. Staff described the practice as a good place to work and reported feeling supported and valued. We spoke with staff prior to attending the practice. Staff we spoke with reported an open door policy throughout the practice and feeling confident that if any issues occurred they would be able to raise them with the management. |

Governance arrangements

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

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

Managing risks, issues and performance

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

| | Y/N/Partial |
|--|-------------|
| There were comprehensive assurance systems which were regularly reviewed and improved. | Partial |
| There were processes to manage performance. | Yes |
| There was a quality improvement programme in place. | Yes |
| There were effective arrangements for identifying, managing and mitigating risks. | Yes |
| A major incident plan was in place. | Yes |
| Staff were trained in preparation for major incidents. | Yes |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Yes |
| Explanation of any answers and additional evidence: At the time of the inspection IPC processes were in place however, these were either not fully embedded or documented. The leadership team were quick to respond to our feedback and within a day of our site visit had produced revised documentation to evidence that the risk had been fully assessed and documented. In the past 18 months the practice had taken on around 2,500 new patients and had prioritised ensuring that these patients had received the appropriate monitoring for their long term conditions or high risk medicines. | |

Appropriate and accurate information

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

| | Y/N/Partial |
|---|-------------|
| Staff used data to monitor and improve performance. | Yes |
| Performance information was used to hold staff and management to account. | Yes |
| Staff whose responsibilities included making statutory notifications understood what this entailed. | Yes |

Governance and oversight of remote services

| | Y/N/Partial |
|---|-------------|
| The practice used digital services securely and effectively and conformed to relevant digital and information security standards. | Yes |
| The provider was registered as a data controller with the Information Commissioner's Office. | Yes |

| | |
|--|-----|
| Patient records were held in line with guidance and requirements. | Yes |
| Patients were informed and consent obtained if interactions were recorded. | Yes |
| The practice ensured patients were informed how their records were stored and managed. | Yes |
| Patients were made aware of the information sharing protocol before online services were delivered. | Yes |
| The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services. | Yes |
| Online consultations took place in appropriate environments to ensure confidentiality. | Yes |
| The practice advised patients on how to protect their online information. | Yes |
| Staff are supported to work remotely where applicable. | Yes |

Engagement with patients, the public, staff and external partners

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

| | Y/N/Partial |
|--|-------------|
| Patient views were acted on to improve services and culture. | Yes |
| The practice had an active Patient Participation Group. | No |
| Staff views were reflected in the planning and delivery of services. | Yes |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Yes |
| Explanation of any answers and additional evidence: | |
| The practice did not have an active Patient Participation Group (PPG) at the time of the inspection. We saw evidence the practice had actively been trying to recruit new members to join the PPG and information was available to patients both in the practice and on their website. PPGs are made up of volunteers interested in healthcare issues which meet to decide ways and means of making a positive contribution to the services and facilities offered by the surgery to patients. | |

Feedback from Patient Participation Group.

| Feedback |
|--|
| As there was not an active PPG in place we were unable to obtain feedback. |

Continuous improvement and innovation

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

| | Y/N/Partial |
|--|-------------|
| There was a strong focus on continuous learning and improvement. | Yes |

| | |
|--|-----|
| Learning was shared effectively and used to make improvements. | Yes |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice demonstrated they have systems and processes in place for learning, continuous improvement and innovation. The practice had regular Clinical Governance meetings at which they would discuss recent complaints, significant events, safeguarding, any nursing or clinical issues and develop new policies and procedures. Also, the partner in the practice met regularly.</p> <p>The practice reviewed the needs of the practice population and had a plan for each group of patients in place, including carers, vulnerable patients, and students. They have worked closely with the local community and were involved in charity fundraising events, for example, the Memory Walk for Alzheimer's research.</p> | |

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.