

Care Quality Commission

Inspection Evidence Table

Church View Practice (1-7586826993)

Inspection date: 6 November 2020

Date of data download: 15 October 2020

Overall rating: No rating given

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

Safe

Rating: No rating given

Safety systems and processes

The practice's systems, practices and processes did not always keep people safe.

Safeguarding

There was a lead member of staff for safeguarding processes and procedures.	Yes
Policies and other documents covering adult and child safeguarding were accessible to all staff. They clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare.	Partial
Staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs) and knew how to identify and report concerns.	Yes
The practice worked in partnership with other agencies to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. Information about patients at risk was shared with other agencies in a timely way.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes

Additional evidence or comments

The local clinical lead salaried GP was the designated lead member of staff for safeguarding processes and procedures. They were present in the practice on Monday, Tuesday, Thursday and Friday. Staff told us that one other member of staff (one of the practice nurses) was present in the practice on Wednesday and acted as deputy lead member of staff for safeguarding processes and procedures during that time. Records showed that this member of staff had been trained in safeguarding to appropriate levels for their role. However, the role of deputy lead member of staff for safeguarding processes and procedures was not contained in their job description.

The provider's safeguarding policy for adults, young persons and children outlined who to contact for further guidance if staff had concerns about a patient's welfare. However, it did not give details of the local clinical salaried GP or practice nurse who were the local designated lead members of staff for safeguarding processes and procedures.

The practice's computer system alerted staff to children that were subject to safeguarding concerns. It also alerted staff to other family members and household members of children who were subject to safeguarding concerns.

Recruitment systems	
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England guidance and if relevant to role.	Yes
There were systems to help ensure the registration of clinical staff was checked and regularly monitored.	Yes

Safety Records	
There were up to date fire risk assessments that incorporated an action plan to address issues identified.	Yes
The practice had a fire evacuation plan.	Yes
Records showed fire extinguishers were maintained in working order.	Yes
Records showed that the practice carried out fire drills.	Yes
Records showed that the fire alarm system was tested regularly.	Yes
The practice had designated fire marshals.	Yes
Staff were up to date with fire safety training.	Yes
All electrical equipment was checked to help ensure it was safe to use.	Yes
All clinical equipment was checked and where necessary calibrated to help ensure it was working properly.	Yes

Additional evidence or comments	
<p>We looked at the training records of six member of staff and found that one was not up to date with fire safety training.</p> <p>After our inspection the provider wrote to us with evidence that the one member of staff who was not up to date with fire safety training had actually received fire warden training on 3 August 2020. This information had not been shared with CQC during the inspection.</p>	

Infection prevention and control	
We observed the premises to be clean and all areas accessible to patients were tidy.	Yes
There was a lead member of staff for infection prevention and control who liaised with the local infection prevention teams to keep up to date with best practice.	Yes
There was an up to date infection prevention and control policy.	Yes
There were up to date infection prevention and control audits that incorporated an action plan to address issues identified.	No
Relevant staff were up to date with infection prevention and control training.	Yes

Additional evidence or comments	
<p>During our inspection we saw that all relevant staff were wearing personal protective equipment (PPE) correctly and adhering to current best practice guidance on COVID-19. For example, wearing face</p>	

coverings and keeping a distance of at least one meter from others.

Hand sanitising gel was available throughout the practice for patients, staff and visitors to use.

There was a lead member of staff for infection prevention and control who was up to date with infection prevention and control training.

Records showed that an infection control risk assessment had been carried out on 25 June 2020 by the practice manager. The risk assessment did not identify risks in any detail other than by use of general headings. For example, environment, specimens and toilets. The risk assessment contained control measures to reduce infection prevention and control risks.

The provider's infection prevention and control policy required the practice manager and nurse lead to provide an annual audit of the practice using appendix three (infection control audit for general practices form) to the provider's quality assurance officer. However, we looked but could not find any records to show that any such audit had taken place. Staff told us that no such audit had taken place.

Risks to patients, staff and visitors

Risks to patients, staff and visitors were not always assessed, monitored or managed in an effective manner.

The provider had systems to monitor and review staffing levels and skill mix.	Yes
There was an effective approach to managing staff absences and busy periods.	Partial
All staff were up to date with basic life support training.	No
Emergency equipment and emergency medicines were available in the practice including medical oxygen and an automated external defibrillator (AED).	Partial
Records showed that emergency equipment and emergency medicines were checked regularly.	Yes
There was up to date written guidance for staff to follow in the event of major incidents that contained emergency contact telephone numbers.	Yes
There was written guidance for staff to follow to help them identify and manage patients with severe infections. For example, sepsis.	Yes
Staff were up to date with training in how to identify and manage patients with severe infections. For example, sepsis.	Yes
The practice had systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Yes
There were a variety of health and safety risk assessments that incorporated action plans to address issues identified.	Yes
There was an up to date health and safety policy available.	Yes
There were up to date legionella risk assessments and an action plan to address issues identified.	Yes

Additional evidence or comments

The following job roles at Church View Practice were vacant and the provider was in the process of recruiting in order to help meet the needs of patients:

- One salaried GP
- One Prescribing Pharmacist

Staff told us that the provider was also in the process of recruiting a Junior Pharmacist to replace the existing one who was planning to leave the practice in the near future.

After our inspection the provider wrote to us and told us that they had been employing locum clinical staff on a long-term basis to help meet the needs of patients.

The practice did not have all emergency medicines that were required to be kept for use in an emergency. For example, dexamethasone oral solution. An assessment of the risk of not keeping this emergency medicine had not been carried out. After our inspection the provider wrote to us with evidence to show that an assessment of the risk of not keeping the emergency medicine dexamethasone had been carried out in September 2020 and mitigated this risk. This had not been shared with CQC during the inspection.

We looked at the training records of six member of staff and found that two (non-clinical) members of staff were not up to date with basic life support training. An assessment of the risk of non-clinical staff not being up to date with basic life support training had not been carried out. Records showed that four clinical members of staff were up to date with online basic life support training. However, we looked but could not find evidence to demonstrate they were up to date with the practical elements of basic life support training.

A legionella risk assessment had been carried out on 23 January 2019 and there was an action plan to address issues identified.

As part of the legionella risk management the temperature of water from hot and cold outlets were monitored and recorded to help ensure hot water was above 55 degrees centigrade and cold water was below 20 degrees centigrade.

Records demonstrated that water samples had been sent for testing and results showed that the building's water system had not been colonised by legionella.

As part of the legionella risk management the flushing of little used water outlets was required, and a record of that activity was to be kept. The provider sent us records to show that these activities were taking place at Church View Practice.

Information to deliver safe care and treatment

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

Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.	Yes
The care records we saw demonstrated that information needed to deliver safe care and treatment was made available to relevant staff in an accessible way.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes

Referrals to specialist services were documented.	Yes
The practice had a documented approach to the management of test results, and this was managed in a timely manner.	Yes
The practice demonstrated that when patients used multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
Additional evidence or comments	
We looked at the records of six patients who were diagnosed with chronic obstructive pulmonary disease (COPD) and saw that their care was based on current best practice guidance (GOLD guidance).	

Appropriate and safe use of medicines
The arrangements for medicines management did not always help to keep patients safe.

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) (01/07/2019 to 30/06/2020) (NHS Business Service Authority - NHSBSA)	0.84	0.89	0.85	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). (01/07/2019 to 30/06/2020) (NHSBSA)	11.5%	9.5%	8.6%	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 (01/01/2020 to 30/06/2020) (NHSBSA)	6.96	5.81	5.35	Variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2020 to 30/06/2020) (NHSBSA)	2.92	2.02	1.92	No statistical variation
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.				Yes

Indicator	Practice	CCG average	England average	England comparison
Medicines that required refrigeration were appropriately stored, monitored and transported in line with Public Health England guidance to ensure they remained safe and effective in use.				No
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
Up to date local prescribing guidelines were in use.				Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).				No
Additional evidence or comments				
<p>We looked at the records of 19 patients who were prescribed high-risk medicines (either warfarin, lithium, methotrexate or azathioprine) and saw that blood test results were recorded as being received and reviewed by a clinician prior to further prescriptions being issued for 18 of these patients. Staff had been unable to obtain a blood sample from the remaining patient during their last phlebotomy appointment. The amount of high-risk medicine prescribed to this patient had been reduced and the practice was in the process of following them up in order to establish an up to date blood test result.</p>				
<p>We looked at the records of five patient who were diagnosed with diabetes, five patients who were diagnosed with dementia and five patients who were diagnoses with poor mental health. We found that health and medicine reviews were carried out and recorded in line with current best practice guidance for all 15 patients.</p>				
<p>We looked at the records of five patients who were receiving or had received end of life care from the practice. We found that all care and treatment delivered to these patients was in line with current best practice and that records had been maintained in an appropriate and timely manner.</p>				
<p>We saw records that showed the temperature of the designated medicine refrigerator at Church View Practice was recorded as being outside of the acceptable temperature limits of between two and eight degrees centigrade on 5 October 2020 (22.5 degrees centigrade) and 20 October 2020 (12 degrees centigrade). There was written guidance for staff to follow when the temperature of designated medicine refrigerators was recorded as being outside of acceptable limits. For example, the vaccine management and cold chain standards document. However, there were no records to demonstrate that staff had taken the correct action to help establish if medicines stored in the designated refrigerator were safe to use. After our inspection the provider wrote to us and told us that the manufacturers of medicines contained in the designated medicine refrigerator were contacted when the temperature was recorded on 20 October 2020 as 12 degrees centigrade. The manufacturers advised the provider that the medicines would not have been compromised and were safe to use. However, there were no records to confirm this.</p>				
<p>After our inspection the provider wrote to us with additional evidence. This additional evidence showed that they had contacted the manufacturers of medicines contained within the designated medicine refrigerator on 10 November 2020 who advised that the deviation in storage temperatures that were found at inspection had not compromised the medicines and that they were safe to use.</p>				
<p>We looked at seven Patient Group Directions (PGDs) and found that four had been completed incorrectly. For example, four of the PGDs had been signed by the nurse after being signed by the GP. They nurse had not therefore been authorised by the GP to use the PGDs to administer medicines. Furthermore, we could not be assured that the GP was aware of which staff were using</p>				

Indicator	Practice	CCG average	England average	England comparison
the PGDs and whether they had the appropriate training to do so at the time of signing.				

Lesson learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events

There was up to date written guidance available for staff to follow to help them identify, report and manage any significant events.	Yes
There was a recording form available that supported the recording of notifiable incidents under the duty of candour.	Yes
Number of recorded significant events in the last 12 months.	5
Records showed that the practice had carried out a thorough analysis of reported significant events.	Yes
There was evidence of learning and dissemination of information from significant events	Yes

Additional evidence or comments

We looked at the records of two significant events reported within the last 12 months which showed that significant events were reported, investigated and any learning from them shared with relevant practice staff. For example, learning from one significant event had been shared with staff to make them aware that patients reporting blood in their urine should be asked to bring a sample of urine into the practice for analysis. This was to reduce delays to necessary referrals.

Safety Alerts

The practice had systems for notifiable safety incidents.	Yes
The practice's systems for notifiable safety incidents ensured this information was shared with staff	Yes
Staff were aware of how to deal with notifiable safety incidents.	Yes
The practice acted on and learned from national patient safety alerts.	Yes
The practice kept records of action taken (or if no action was necessary) in response to receipt of all national patient safety alerts.	Yes

Well-led

Rating: No rating given

Leadership, capacity and capability

Local clinical leadership (including on-site clinical supervision) was unclear.

Local leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
Local leaders had identified the action necessary to address challenges to quality and sustainability.	Partial
There was a clear leadership structure and staff felt supported by the GP partners and practice management.	Partial

Additional evidence or comments

Clinical leadership (including clinical supervision) at Church View Practice was unclear. One member of staff told us that clinical leadership including clinical supervision was provided locally at Church View Practice by a local clinical lead salaried GP who was present in the practice for four days per week. Staff at the provider's head office told us that clinical leadership (including clinical supervision) was provided remotely by the provider's Registered Manager on the one day per week that the local clinical lead salaried GP did not work. However, staff at the practice told us that clinical leadership (including clinical supervision) was provided locally by a locum GP (who was employed via an agency) on the one day per week that the local clinical lead salaried GP did not work. Staff told us that there was not a written job description for the locum GP (who was employed via an agency). Instead, they were provided with other documentation detailing their role and responsibilities whilst at work in Church View Practice. For example, a welcome document, a practice information document, a shift information document and a data entry document. We looked at these documents and found that they did not indicate that the locum GP (who was employed via an agency) was required to act as the local clinical lead.

Overall leadership was provided by DMC Healthcare Limited centrally by staff at their head office. This included a managing director, a chief executive officer, a medical director, a finance director, a chief technology officer, a head of governance, a head of quality, a head of marketing, a head of planning, a head of legal and a head of human resources.

Staff told us that the local clinical lead salaried GP and practice management were approachable and always took time to listen to all members of staff. Staff also told us that DMC Healthcare Limited head office staff were contactable remotely. However, staff said that the Registered Manager, who was legally responsible for the day to day delivery of regulated activities at Church View Practice, did not work on-site there. They told us that the Registered Manager attended Church View Practice every Tuesday for approximately two hours on an informal basis to speak with staff and to establish if they had any concerns only.

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients.

The practice had a mission statement which reflected their vision.	Yes
The practice planned services to meet the needs of their patient population.	Yes

Governance arrangements

Governance arrangements were not always effective.

There was a clear staffing structure and staff were aware of their own roles and responsibilities.	Partial
The practice had systems that helped to keep governance documents up to date.	Yes
Governance documents that we looked at were up to date.	Yes
The arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were effective.	Partial
The practice had processes to manage current and future performance.	Yes
Clinical and internal audit was used to monitor quality and to make improvements.	Partial
Records showed that the practice had analysed all clinical audit results and implemented action plans to address findings.	Partial
Records showed that all clinical audits had been repeated or were due to be repeated to complete the cycle of clinical audit.	Yes
The practice had written guidance for staff to follow in the event of major incidents.	Yes
Written major incident guidance contained emergency contact telephone numbers for staff.	Yes
The provider complied with the requirements of the duty of candour.	Partial

Additional evidence or comments

The practice was unable to demonstrate their processes and systems were effective in the management of risks from: all staff not being up to date with essential training (fire safety training and basic life support training); management of infection prevention and control; not keeping all emergency medicines that were required to be kept; management of appropriate authorisations to allow staff to administer medicines; management of medicines that required refrigeration.

Clinical audit had only been used to monitor quality at Church View Practice since September 2020 when the junior pharmacist had started working there. Only one of the five clinical audits (all carried out by the junior pharmacist) had been repeated to complete the cycle of clinical audit and demonstrate improvements. Action plans for two of the clinical audits had either not yet been decided or not yet implemented. However, there were plans to repeat all clinical audits.

We looked at management records for one formal complaint received by the practice and saw that the patient had received a written response, that included outcomes and learning, in a timely manner.

Verbal complaints were managed by the practice manager. However, they were not recorded on the provider's Datix system in line with the patient feedback policy (complaints, comments, compliments).

Records of the two significant events that we looked at showed that both patients had been contacted by the practice with outcomes and learning in a timely manner.

Engagement with patients, the public, staff and external partners

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

A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.	Yes
The practice had an active patient participation group.	Yes
The practice gathered feedback from patients through the patient participation group.	Yes
The practice gathered feedback from staff through staff meetings, surveys, appraisals and discussion.	Yes

Additional evidence or comments

We looked at the NHS Choices Website and saw that 2 reviews had been left by patients about Church View Practice in the last 12 months. The practice had responded to one of these reviews. After our inspection the provider wrote to us with evidence demonstrating that the practice had now responded to both reviews left on the NHS Choices website.

The practice had a patient participation group (PPG) but meetings had been suspended since March 2020 due to the current pandemic. Records showed that the practice had remained in contact by email with PPG members during the pandemic and that PPG meetings were recommenced virtually on 19 August 2020.

We looked at the personnel records of six members of staff. Records showed that all six had received an appraisal. However, three of the appraisal records were not dated so we could not be sure when they had taken place. After our inspection the provider wrote to us with other evidence that demonstrated that the three appraisals that were not dated had been carried out within the last 12 months.

Reviews left on the NHS Choices website

Total reviews	2
Number of reviews that were positive about the service	1
Number of reviews that were mixed about the service	0
Number of reviews that were negative about the service	1

Experience shared with CQC directly via our website

Total received	0
Number received which were positive about the service	0
Number received which were mixed about the service	0
Number which were negative about the service	0

Examples of feedback received	Source
<ul style="list-style-type: none"> Feedback we received from patients about the care they received was limited. Comments about the care and treatment patients received at Church View Practice were mixed. Patients indicated staff at Church View Practice were helpful whilst others indicated staff were not always helpful and they did not always listen. 	Reviews left on the NHS Choices website Experience shared with CQC directly via our website

Continuous improvement and innovation

Systems and processes for learning and continuous improvement were effective.

The practice made use of reviews of complaints and significant events.	Yes
Openness, honesty and transparency were demonstrated when responding to incidents.	Yes
Learning was shared and used to make improvements.	Yes

Additional evidence or comments

Records showed that learning and dissemination of information from complaints and significant events took place at Church View Practice.

Patients involved in significant events were contacted by the practice in an open, honest and transparent way after investigations had taken place. For example, records showed that when an audit identified that some patients had been prescribed more than 28 days supply of high-risk medicine, staff had contacted all patients involved to explain what had happened and how the practice planned to manage their medicines going forward.

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)	≤ -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
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.