

# Care Quality Commission

## Inspection Evidence Table

### The Village Surgery (1-5626948725)

Inspection date: 5 and 6 October 2021

Date of data download: 01 October 2021

## Overall rating: Good

During the last inspection we rated the practice requires improvement overall with caring and responsive services rated good, and safe, effective and well led services rated requires improvement. We rated all population groups as requires improvement overall because of the issues identified in the effective domain. We found the following areas where the provider must improve:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

We found the provider should:

- Act to complete the actions highlighted in the fire risk assessment of 6 February 2020.
- Act to ensure the building plans for the new practice premises are completed as scheduled so the space constraints of the current location are resolved in a timely way.
- Act to achieve the 95% WHO based target for childhood immunisations.
- Act to achieve the cervical cancer screening 80% national programme coverage measure set by Public Health England.

At this inspection we have rated the provider as Good. We have noted that the practice has taken action to improve in all the areas highlighted above.

# Safe

# Rating: Good

At the last inspection we rated the provider as requires improvement for being safe because:

- Systems for the appropriate and safe use of medicines and for managing safety alerts needed improvements.

At this inspection we have rated the provider as Good for being safe. The practice now has effective systems in place for managing safety alerts.

## 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
Explanation of any answers and additional evidence:	
The practice took a proactive approach to safeguarding. They had safeguarding meetings every two months. The practice rotated the review of adult and child safeguarding between meetings? Meetings were attended by Advanced Nurse Practitioners and GPs. Urgent issues were discussed during daily clinical huddles and weekly clinical meetings.	
We reviewed safeguarding meetings minutes and saw evidence that safeguarding concerns were documented in patient notes. Safeguarding records were reviewed and updated appropriately.	
The practice had registers for children in need and a safeguarding plan. Their adult list were broken down into sub lists.	

## 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 Public Health England (PHE) guidance if relevant to role.	Yes
Explanation of any answers and additional evidence: During the inspection we reviewed five staff files. The practice had a system in place for checking the professional registration of employees. The practice had a checklist included in the Human Resources (HR) folder for each member of staff to ensure that references were obtained, and appropriate checks were carried out.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 3 September 2021	Yes
There was a fire procedure. Date of fire risk assessment: 3 September 2021	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: At the last inspection, it was identified that some actions from the fire risk assessment in 2020 were still outstanding. At this inspection, we saw that the practice had carried out an external fire risk assessment in September 2021. The practice shared evidence to confirm that the fire alarm was being tested weekly. The last fire drill was carried out in September 2021. There were a few areas that needed addressing following the fire risk assessments such as installation of a new fire detector which had been actioned. Also, more fire extinguishers were provided due to the size of the building.	

## 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: September 2021	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
At the last inspection the infection control policy did not specify who the infection control lead was at the practice. At this inspection we have seen a revised policy that identified the infection control lead.	

The way clinical waste was managed has been changed. The nurses empty the clinical rooms daily. The waste was placed into clinical waste bins and located in a designated secure area outside the practice.

The practice had ordered wipe clean chairs following the infection control audit.

### 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

Explanation of any answers and additional evidence:

The practice was aware of the need to increase staffing to meet patient needs at the time of our last inspection.

At this inspection, we noted there had been several changes to staffing. The practice had employed an additional salaried GP in October 2020. A healthcare assistant had joined the team in October 2020. An advanced nurse practitioner was employed in November 2020. A lead nurse had joined since March 2021.

## 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.	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:	
The practice was up to date with patient summarising and had trained staff to undertake this task. During the inspection, we saw that urgent tasks were dealt with immediately. These were actioned on a daily basis.	

## Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.79	0.68	0.69	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). (01/07/2020 to 30/06/2021) (NHSBSA)	8.6%	11.3%	10.0%	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 (01/01/2021 to 30/06/2021) (NHSBSA)	6.50	5.85	5.38	Tending towards variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	53.0‰	67.4‰	126.1‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	0.64	0.53	0.65	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	4.3‰	5.0‰	6.7‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	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

Medicines management	Y/N/Partial
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.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
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.	Yes
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 PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>During the last inspection, we found that the practice stocked all but two of the recommended emergency medicines. After our inspection, the practice sent us the relevant written risk assessments relating to the above two absent medicines.</p> <p>At this inspection, we found that the clinical pharmacist was given the responsibility of ensuring that patients on high risk medicines were monitored in a timely manner. Searches had been set up on the practice clinical system. Searches were being run on a quarterly basis and identified patients were contacted if any monitoring were due.</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:	12
Number of events that required action:	12
Explanation of any answers and additional evidence:	
<p>All staff were encouraged to report incidents. There was an electronic form for this, and they were discussed at the weekly clinical meeting. Anything serious was resolved, if possible, on the day. Trends were monitored at monthly meetings, records showed that all staff were involved .</p> <p>During our inspection we reviewed the significant events log which the practice regularly updated. We saw that there were 12 incidents recorded in the last 12 months. We reviewed a sample of these incidents which showed the date the incident happened, how it was resolved, lessons learned and what had been put in place to prevent it from happening again.</p>	

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

Event	Specific action taken
Patient rang up with abdominal pain and receptionist advised to take paracetamol. It later transpired they had a more serious condition which needed attention.	Following this the nursing team provided training to the reception team to prevent this from happening again. All receptionists had completed training to increase understanding around red flags.
Patient was unaware of how the practice texting system worked.	Action was taken to explain this more fully to patients and further training provided to the reception team so that they could help with queries of this nature in the future. Patients were now being informed at the start of their consultation that



	photographs can be shared with GPs. All receptionists were not aware of this procedure before this event occurred.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection, we found that the practice did not have an effective system to check that safety alerts had been acted upon.</p> <p>At this inspection, we saw that the practice had introduced an electronic system for managing safety alerts. The clinical pharmacist had the responsibility of monitoring all alerts, including MHRA alerts. They maintained a spreadsheet with alert details and an internal email was sent to all relevant staff members. Details of the safety alerts were discussed on a weekly basis at the clinical huddle.</p> <p>The practice aimed to use their electronic system to manage safety alerts in the future. This had not been started at the time of our inspection, but plans were in place for this.</p>	

## Effective

## Rating: Good

At the last inspection, we rated the provider as requires improvement for being effective because:

- Clinical outcomes for some long-term conditions were lower than expected compared to CCG and England averages.

At this inspection, we have rated the provider as Good because we have seen improvements. We have carried out clinical searches on the practice computer system to review long-term disease management. We have seen that the practice is monitoring patients effectively and ensuring that patients are seen in a timely manner with appropriate blood tests taken as part of their monitoring.

*QOF requirements were modified by NHS England 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.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	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 had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
A health and wellbeing coach was available one day a week. Identified patients had access to half an hour telephone appointments and patients had fed back that this was beneficial.	
Each GP had a particular clinical lead area and discussed any major changes in guidance at clinical meetings.	

Patients' wishes were taken into account. This was seen from notes' reviews from searches.

All staff had received training on the recognition of ill patients and particularly the recognition of sepsis, mainly using an online platform. There was evidence in clinical notes of safety netting information given to patients when necessary.

## Effective care for the practice population

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

- During this inspection, we carried out a number of clinical searches to review long-term disease management. We found that the monitoring of Disease-modifying antirheumatic drugs (DMARDs medicines used to treat patients with rheumatoid arthritis) was effective.
- We saw that patients on high risk medicines were monitored appropriately.
- We carried out a random sample of medicine reviews and found that all five patients had been reviewed within the last year and no issues were found. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

- We reviewed five sets of patient records to look at asthma reviews and found they had all been carried out within the last year. Patients with asthma were offered an asthma management plan.
- We identified some patients who were overdue their thyroid blood tests. All these patients had normal levels during their last check. The practice contacted these patients straight away following our inspection.
- We carried out a notes review during this inspection. No issues were identified with the searches. There was appropriate safety netting when required.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. Everyone has a lead area with long-term conditions.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.

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) (01/04/2019 to 31/03/2020) (NHS England)	88	108	81.5%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	91	98	92.9%	Met 90% minimum
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) (01/04/2019 to 31/03/2020) (NHS England)	91	98	92.9%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	91	98	92.9%	Met 90% minimum

The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	105	116	90.5%	Met 90% minimum
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Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

### Any additional evidence or comments

- The practice had met the minimum 90% target for four childhood immunisation uptake indicators. The practice had not met the 90% target for one of the childhood immunisation uptake indicators below. The practice were working on improving uptake.
- The practice had employed an administrator in June 2020 who had responsibility for managing the recall of patients for childhood immunisations and the monitoring of uptake.
- The child immunisation programme was taken out of practices during the first part of the pandemic by the local Clinical Commissioning Group (CCG). Practices have been responsible for childhood immunisations again since August 2020.
- The Practice moved from a different electronic system in 2019 and a considerable number of immunisation read codes did not transfer correctly. These codes were picked up by the new electronic system and this meant that some patients were flagging up as not having had an immunisation when they had. This was checked on a weekly basis to ensure that the practice had the most up to date information.
- Each month a report was run off the clinical system showing the patients due to have immunisation and those that have gaps in their immunisation record. Patients were then invited and/or asked to bring in a copy of the immunisation record so that any immunisations already given could be coded onto the system.
- The administrator sent text messages, and if necessary, also emailed and wrote to patients when inviting them to book an appointment. If there was no response, then the administrator follows up with a phone call. Patients who did not attend were sent a text message from the practice.
- Childhood immunisation records were asked for at registration to ensure the practice had captured all the necessary information.
- Practice nurses had attended vaccine hesitancy training, as the practice found a number of parents to be declining vaccinations for their children.

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 31/03/2021) (Public Health England)	69.4%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	68.3%	69.1%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	60.8%	61.4%	63.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	51.7%	51.1%	54.2%	No statistical variation

#### Any additional evidence or comments

- They were responsible for dealing with the Prior Notification Lists and inviting patients who were showing as overdue cervical screening on the search within the clinical system. Invites were sent out monthly and patients were followed up if they did not attend.
- Uptake was extremely low during March, April and May 2020 as patients were reluctant to come to the surgery due to the pandemic lockdown.
- The Practice Nurse employed in February 2020 had her cervical screening training halted due to the pandemic. This training has now been completed and the nurse was undergoing the practical supervision and was being mentored within the practice.
- The Practice was aware that improvements were required at the time of the last inspection and had worked hard over the last nineteen months to ensure that all recommendations made in the report were acted upon.

## 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

<p>The practice shared several audits which had been repeated; for example, an audit on B12 injections. The audit highlighted that many patients could take oral B12 which they could buy over the counter. The results of the audit showed a significant reduction in injections needed to be given.</p> <p>The practice received regular prescribing data from the CCG, and this was regularly reviewed by the prescribing lead.</p>
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## 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:	
<p>We reviewed appraisal documentation during our inspection. We did find a few members of the team had appraisals which were overdue as they had gotten a little bit behind during Covid. There were plans in place to carry out all the rest of the appraisals shortly after our inspection.</p> <p>There was one non-medical prescriber at the practice, namely the Advanced Nurse Practitioner. There was a regular, daily sessional slot for a GP to discuss concerns from their consultations.</p>	

## 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
Explanation of any answers and additional evidence:	



Information between the practice and other providers was shared by a mixture of telephone and email means. The practice used an electronic system which had several standardised letter templates.

Information was shared with Social Services by letter, telephone and sometimes email. Special notes were used quite often in palliative care cases.

## 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
Explanation of any answers and additional evidence:	
Health promotion advice was sent out to patients. The practice had access to all support services, such as weight reduction, exercise and smoking cessation. It also had a social prescriber. Patients who were at risk of long-term conditions were referred to these services.	

## 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.	Yes
Explanation of any answers and additional evidence:	
Wrist, knee and finger injections were carried out at the practice since April 2021.	
Mental health capacity assessments were carried out as necessary and examples were seen during our inspection. Also, all clinical staff received Gillick competency training, particularly for patients with learning disabilities.	

The service uses DNACPR with appropriate discussions and individualised care plans. Examples were seen during our inspection. We looked at four records and these have all been handled appropriately. In one case the patient lacked capacity so was discussed with a relative of the patient.

## Well-led

## Rating: Good

At the last inspection, we rated the provider as requires improvement for being well led because:

- Assurance systems related to medicine management, management of safety alerts, effective clinical needs assessment care and treatment needed a review, as only limited performance information was currently available in order to highlight performance issues and deliver positive patient outcomes.

At this inspection, we have rated the provider as good for being well led because they have made improvements in the areas highlighted above.

### 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:	
There have been discussions about bringing in a new salaried GP from 1 of April 2022 to lighten the load but also to forward plan should any of the partners retire.	
The practice had coped with the many changes which the National Covid pandemic has produced. It also coped with two changes of practice manager during the year and, in August 2021, the move to a bigger, new premises.	

### 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:  There was an open and inclusive leadership style and collaborative teamwork. The practice mission statement was 'To create a happy, effective and safe workforce, capable of delivering services to enable and empower our patients to look after and maintain their own physical and mental wellbeing'.	

## 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:  All staff had undertaken equality and diversity training.	

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

Source	Feedback
Staff	Staff we spoke with told us that they were supported to carry out their roles. They were encouraged to develop, and they felt respected. They told us that communication through staff meetings, emails and verbal was good and had kept them informed of developments.  There had been some difficulties with staff changes but people now feel supported.

## Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes

Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Staff accessed practice specific policies and procedures on the practice intranet system. There were designated leads for specific governance areas. Everyone had a comprehensive job description and had knowledge and training in other areas. There was a weekly practice meeting between the three partners and practice manager. Governance issues could be discussed as well as other practice business.</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.	Yes
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:	
There was a set business continuity plan. All the partners had this as well as the practice manager. All contact details were on there.	
There was an incident on the second day in the new building where they had locked themselves out of the building. The practice have learned for this. They rang the contractors who gave access to the building. This enabled them to implement their business continuity plan early on.	

### The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes



Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence:	

## 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
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
Explanation of any answers and additional evidence:	
<p>At the last inspection, the practice had limited information to review and act on in relation to medicines management, management of safety alerts, effective needs assessment and care and treatment. Clinical information relating to the QOF, cervical cancer screening and childhood immunisations were lower than expected compared to the CCG and England averages.</p> <p>At this inspection we found that there was now an effective system in place for managing safety alerts and long-term disease management.</p> <p>Whilst the cervical screening and childhood immunisation were slightly below target the practice had made improvements in these areas.</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.	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
The practice actively encouraged patients to use e consult but still welcomed patients to call in if they preferred to use the phone.	

## 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.	Yes
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 manager explained that patients took every opportunity to feedback.	
One of the partners managed the Facebook and Twitter page. The practice manager managed the practice website.	

## Feedback from Patient Participation Group (PPG).

Feedback
<p>The PPG used to meet three or four times annually, face-to-face in the practice but because of the Covid restrictions, they have met on zoom.</p> <p>The practice were keen to start meeting regularly again with the PPG. They had plans in place for this.</p> <p>The practice had implemented changes following recommendations from the PPG. For example, in the new building there were two receptionists on the front desk now. One on the phone and one greeting patients.</p>

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	

The practice had successfully moved locations at short notice ensuring minimal disruption to patient services and at the same time retaining most of the previous patient population.

To meet increased demands for on the day appointments and to make effective use of available resources, the practice had set up a GP triage system for requests for on the day appointments.

As part of the CCG enhanced community framework realignment project the practice was responsible for patients living in one nursing home and one home for patients with learning difficulties.

### **Examples of continuous learning and improvement**

Clinical and administration staff had time for mandatory training. There was a regular daily clinical huddle to discuss any clinical issue. There were also regular clinical meetings.

The practice was an active constituent of the PCN. The practice were currently taking place in a pilot for NHS screening. This will be reviewing HBA1c levels and cholesterol levels. They will be undertaking the training for this on 25 October 2021 with an external company.

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

## Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- 
- $\text{‰}$  = per thousand.