

Care Quality Commission

Inspection Evidence Table

Pinehill Surgery (1-11392382584)

Inspection date: Remote searches undertaken 3 November, interviews 3,4,5,8 November and on site 9 November 2021 .

Date of data download: 26 October 2021

Overall rating: Good

Safe

Rating: Good

We rated the Safe key question as Requires Improvement at the last inspection in September 2019. We reported a continued shortage of administrative/reception staff and although systems were working more effectively, staff continued to feel under pressure. We also found gaps in the security system for prescription stationery, some Patient Specific Directions (PSDs) had not been approved and safety alerts had not been responded to appropriately.

From this inspection, we found the practice had recruited additional staff and established improved systems for managing the workload. There was a safe system for the management of paper prescriptions and PSDs and the practice manager ensured safety alerts were acted upon.

Although there were no breaches of regulations, we found areas where the practice should improve.

We found that during COVID-19, regular multi-disciplinary engagement in relation to vulnerable adults and children had been less frequent and the practice was liaising with partners to review this. The practice's fire system was in need of updating and this was a topic of discussion with the clinical commissioning group (CCG). Although the clinicians had decided the practice did not need to stock opiate medicines, nor the medicines administered to reverse the effects of opiates, this approach had not been formally risk assessed. The practice had a system for recording, reviewing and learning from incidents, but the rate of incident reporting was low. The practice had not set up a process to audit the implementation of alerts to check the correct actions had been taken and, where appropriate, sustained.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	P
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	P
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The registered manager was the safeguarding lead, having taken over this role from a previous GP partner. The GPs were trained to level 3 safeguarding for adults and children. Staff had either achieved the training required for their roles, or were booked onto additional courses during November 2021 in order to meet their required levels. We found the safeguarding policies for children and for vulnerable adults required some updates, for example to reflect the latest Intercollegiate guidance, and this was being addressed at the time of the inspection. We saw examples of minutes of meetings with other health and social care professionals in relation to patients at risk of harm. Staff told us these meetings had been less frequent during the COVID-19 pandemic which meant there was a risk of information not being shared effectively. The practice had a system for reviewing and updating the registers for vulnerable patients. All staff we spoke with were confident they would contact the safeguarding lead if they had concerns. For example, staff outlined recent actions taken in response to risks identified by reception staff in relation to a child. The concern had been escalated and led to further investigation of the patient's medical history, to assess if there was a safeguarding concern and a need for referral. The practice held registers of vulnerable people, including vulnerable adults and children at risk or with protection plans. These were regularly reviewed and any issues raised for discussion within the practice. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice manager had established a process for recruitment. The practice ensured staff checks were carried out which included Disclosure and Barring Service (DBS) checks (to check whether a person has a criminal record that would make them unsuitable to work with children or vulnerable adults), requests for references and a review of the candidate's career history. They asked for evidence of professional registration, qualifications and immunisation status as appropriate for their role. 	

- New staff confirmed there was a comprehensive recruitment process and they received a contract and a staff handbook.
- They completed their mandatory training as part of their induction.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
There was a fire procedure.	Y
Actions from fire risk assessment were identified and completed. Date of fire risk assessment: September 2021	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff had completed fire training and there were appointed fire marshals for the service. The practice's fire equipment was tested in January 2021. The actions for the last fire risk assessment identified a recommendation for the replacement of the fire system with an updated, integrated system. This was an issue the practice had identified for further investment in the premises, to include a wider refurbishment programme. This was a topic of discussion with commissioners. In mitigation, the practice had equipment to enable staff to 'fire pistols' and thereby extend an alarm across the entire building. The practice held fire drills twice a year.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 1 September 2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff had completed infection prevention and control and policies and procedures had been updated to reflect the needs of the COVID-19 pandemic. Actions identified in the September 2021 audit had been completed and in addition, the practice had introduced 'I am clean' stickers in clinical areas, to highlight when equipment had been cleaned. • The practice had recently recruited a new cleaning contractor and the small cleaning cupboard contained appropriate COSHH files and colour-coded cleaning equipment, for use in different areas of the building. • We observed staff were vigilant in cleaning to minimise the risk of cross contamination. • We found one closed clinical waste bin in the treatment room which should have been removed. Its removal was actioned on the day. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Since the last inspection, the practice had recruited a new receptionist and administration tasks had been reallocated with systems and protocols in place. Staff were able to cover for each other at times of absence. • A new GP partner had joined the practice since our last inspection and the two GPs managed their sessions to ensure there was always one GP on site. Reception staff commented there was always a GP on site, which they found reassuring. • Staff said they received effective induction and the practice had induction programmes for different roles, including for locum staff. • All staff had completed their required training in basic life support and anaphylaxis, and there was guidance available for staff to refer to if they suspected sepsis. • The emergency trolley was available and the lead nurse undertook routine checks on equipment and medicines. 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice has set up referral protocols appropriate for the four different acute hospitals their patients attended. 	

- To improve clinical oversight of test results, the practice had set up a new system in October 2021, so test results were checked based on their priority and colour coded as tasks. For example, 'red tasks' were reviewed by the GP and reported directly to the patient, 'amber tasks', which were less urgent, could be communicated by the lead nurse if the GP had not managed to make contact with the patient and 'green tasks' could be addressed by reception staff.

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)	0.43	0.66	0.69	Variation (positive)
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)	8.7%	11.4%	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)	5.00	5.87	5.38	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	115.9‰	110.6‰	126.1‰	No statistical variation
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)	0.12	0.61	0.65	Significant Variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	4.9‰	9.2‰	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.	Y

Medicines management	Y/N/Partial
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	NA
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	P
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the last inspection we identified that the practice did not have a system for ensuring blank prescriptions were managed safely. Since the last inspection, the practice had implemented a clear system for issuing and collecting the small number of blank prescriptions placed in the printers in the GP consultation rooms. The prescription numbers were noted and checked when they were collected at the end of the session. Staff reported this system worked well, and any discrepancies were identified and investigated promptly. At the last inspection we found Patient Specific Directives (PSDs), which are written instructions, signed by a GP to be administered to a named patient, had not been consistently signed and dated. When we visited for this inspection we found that PSDs had been completed appropriately. The practice held emergency medicines and equipment, and these were located in a place accessible to staff if required. Stock levels and expiry dates were monitored. The practice did not stock opiates nor the drug used to reverse the effects of opiates. The clinicians had 	

Medicines management	Y/N/Partial
<p>discussed this and determined they did not need to stock opiates, however this had not been formally risk assessed.</p> <ul style="list-style-type: none"> The practice had a process for managing repeat prescription requests, with appropriate clinical review and authorisation. Clinicians carried out structured medicine reviews for patients with long term conditions. Vaccines were stored appropriately and there were safe systems for monitoring the fridge temperatures. There had been a failure of one fridge that had then been removed from service. The lead nurse had researched the impact on the stored medicines and as a result of the risk assessment had disposed of the stored medicines. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	P
Staff understood how to raise concerns and report incidents both internally and externally.	P
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	One
Number of events that required action:	One
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> There had been one reported incident in the past 12 months, and this related to entering the administration of a flu vaccine into the wrong patient's record. This had been identified and corrected when the mistaken patient attended for their vaccination. The event was investigated and the patient received an apology. As a result of this incident, the practice had changed the procedure for vaccine administration, such that the vaccinator was supported by another member of staff who helped check patient identity and log the administration. Staff told us they understood the value of reporting safety incidents and near misses and could describe the process and gave examples of where changes had been made in response to incidents. For example, when vaccines were disposed of following a fridge failure. Although this incident had been managed, communicated and acted upon, the practice had not logged this as an incident. Practice management acknowledged the number of incidents recorded was low. 	

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

Event	Specific action taken
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Flu vaccination given but entered on the wrong patient's details.	Mistake noticed when the mistaken patient came in for their vaccine. The correct patient was located, and their record was updated.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the previous inspection we found the practice did not have a system to ensure medicine safety alerts were actioned appropriately. For this inspection, the practice showed us they had set up a system where the GP partners advised the practice manager of alerts, such as those from the Medicines and Healthcare products Regulatory Agency (MHRA). The practice manager logged each safety alert and printed them for the GPs to consider and respond. The GPs decided what action was needed and by whom. This was recorded by the practice manager and processed. The practice had not set up a process to audit the implementation of alerts to check the correct actions had been taken and, where appropriate, sustained. 	

Effective

Rating: Good

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y

Explanation of any answers and additional evidence:

- Clinical management was in line with current practice as evidenced from information gathered during a range of searches of patient records, including those for patients prescribed high risk medicines and patients with long term conditions.
- Our reviews of patient records showed they were completed in detail and there was evidence of regular reviews and appropriate referrals. For example, patients prescribed disease-modifying antirheumatic drugs (DMARDs; a group of medications commonly used in people with rheumatoid arthritis) had regular health reviews in line with best practice. The practice actively prompted patients to attend for their three-monthly blood tests.
- We reviewed records of those patients with chronic kidney disease and found their care was appropriate. There had been some coding issues which the practice was aware of and correcting.
- The practice supported patients with asthma well, with appropriate management plans in place.
- We found the practice had set up annual blood tests for patients prescribed spironolactone (diuretics prescribed for heart failure, but can cause renal impairment), whereas best practice guidelines were for these to be carried out six-monthly. This was addressed at the time of the inspection with patients invited to attend for tests. We did not consider this to have been a risk since the cohort of patients were regularly reviewed as they were also taking other medicines that prompted regular reviews.
- Where we found individual discrepancies in our review of records, the practice was proactive in resolving the issues promptly. These issues were not considered to have put patients at risk of harm.

- The practice had good systems for undertaking medication reviews.

Effective care for the practice population

Findings

- The practice had an effective system for updating patient registers, were used to arrange regular reviews and health checks. These registers had been adapted during the COVID-19 pandemic to include those who might be vulnerable and need a wellbeing check.
- A locum GP held clinics for minor female surgical procedures once every six weeks.
- 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.
- The service set up monthly clinics on Saturdays specifically for patients with chronic diseases who may have difficulty accessing the surgery at other times.
- Tests were requested in timely way to inform reviews of patients with asthma and chronic obstructive pulmonary disease (COPD).
- 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 with diabetes received regular reviews including foot checks. The practice also offered lifestyle guidance.
- 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 and those with a mental health illness were offered an annual health check. The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- The GPs requested longer appointments for those patients with complex health needs.
- The doctors provided regular palliative care and cancer reviews. 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 ensured reception staff were advised of any patients who had died, to ensure they communicated effectively and compassionately with relatives.
- 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.
- Patients with poor mental health, including dementia, were referred to appropriate services. Staff provided an example of having concerns about a patient's mental health, highlighting this with the GP and the practice then supporting the patient with a mental health assessment and social support.

Management of people with long term conditions

Findings

- The practice had good systems for monitoring the health of patients with long term condition. The GPs carried out all their monitoring, and made changes to their medicines and made onward referrals directly.
- Records showed patients with asthma had regular medicine reviews and asthma management plans.
- There were systems for GPs to review information shared by hospitals and act upon it directly.
- Staff only undertook reviews of patients once they had received specific training, for example the GPs only reviewed patients with long-term conditions as the nurse had not completed training in this field.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.

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)	30	30	100.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	47	51	92.2%	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)	47	51	92.2%	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)	47	51	92.2%	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)	39	43	90.7%	Met 90% minimum

Any additional evidence or comments

- The practice had effective systems to call parents/carers for childhood vaccines, as demonstrated by the 100% vaccination rate of children aged one, for their primary course of immunisations.
- The newly appointed lead nurse had completed training in the administration of childhood immunisations.

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)	73.8%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	72.6%	71.5%	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)	58.5%	67.5%	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)	50.0%	52.7%	54.2%	No statistical variation

Any additional evidence or comments

- The practice nurse had recently completed their training in cervical cancer screening, and had plans to set up additional clinics to improve take-up.
- The practice contacted all patients that failed to attend screening to encourage them to make an appointment. If this failed, the practice nurse aimed to call those who did not respond, to provide reassurance and promote uptake.

Monitoring care and treatment

The practice undertook quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y

The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	P
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

<ul style="list-style-type: none"> The impact of COVID-19 meant that there had been a limited programme of clinical audits, however the practice had carried out audits in relation to antimicrobial stewardship, use of high-dose opiates and immunisation for individuals with asplenia and splenic dysfunction (where a patient's spleen does not work correctly and increases the risk of infection). These audits had identified only minor actions for the practice and these had been implemented. The practice had two audits underway at the time of the inspection, in relation to post minor surgery infection rates and antibiotic use in patients with suspected urinary infections.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff said they were supported and encouraged to gain skills and develop their roles within the practice. For example, the practice supported one staff member to attend a university course to gain the practitioner assistant qualification. The new lead nurse had attended a range of training courses to develop their skills in practice nursing, and further training was planned. Clinical staff told us they had received supervisions and a range of useful training in their specific roles, and there were a range of protocols to follow to ensure they followed effective and safe procedures. For example, in making referrals. 	

- Staff said they had received effective inductions and good access to supervision as well as informal guidance from colleagues. New staff required sign-off of their induction programmes, to demonstrate they had achieved the agreed level of competency.
- The practice provided monthly training afternoons for staff.
- The practice used locum staff, generally on a routine basis, and these were fully inducted as part of the medical team.
- Staff had regular appraisals and these were formal opportunities for staff to discuss their career plans. They said they could also discuss this informally at other times during the year.

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.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There were agreed protocols for referring patients to the different secondary care services available locally, all of which required different systems. • The practice attended weekly multi-disciplinary team meetings with community nursing services. • Through the Primary Care Network, the practice involved different health professionals to support patients with their individual health needs. For example, the practice could offer referrals to social prescribers, a community dietician and a first-contact community physiotherapist. 	

Helping patients to live healthier lives

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

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

- Through the Primary Care Network, the practice could offer referrals to social prescribers and a community dietician to offer assistance with lifestyle changes.
- The practice signposted patients to a range of local services and support groups.
- There was a systematic approach to inviting patients for health assessments. The practice maintained registers of patients with, for example, a learning disability, mental health needs, and patients with dementia, and reviewed these monthly to prompt regular reviews.

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We reviewed records that contained DNACPR decisions and there was evidence these were made in line with legislation and were appropriate for the patient and their family. If a DNACPR was in place, this was clearly identified in the patients' records and a member of the administration team was responsible to ensuring these were in place and reviews were prompted. • Staff gave examples of when they obtained written consent, for example for a minor operations and when they assessed a patient's capacity to give consent to a procedure. • Staff we spoke with demonstrated an understanding of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. 	

Well-led

Rating: Good

We rated Well-led as Requires improvement at the last inspection in September 2019. At this inspection, we found there was more stable leadership, additional staff had been recruited and areas identified for improvement at the previous inspection had been addressed. These included management of blank prescription stationery, PSDs, information governance and the display of their CQC rating on their website.

Although there were no breaches in regulation, we found minutes of meetings did not have a standard agenda to ensure key topics were prompted and discussed regularly. We also found that due to the pandemic, routine engagement with patients and the patient participation group had been put on hold.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• When we last inspected this service the practice had just embarked on a period of change, with a new practice manager.• At the time of this inspection, there was a new partnership of two GPs. They provided medical cover throughout the week, and aimed to cross cover for each other wherever possible. The new GP partner was training to be GP trainer and the practice aimed to be a training practice going forward.• The practice manager had made changes to the staffing structure and recruited additional reception/administration staff. Staff commented the new partnership arrangement was working effectively.• The practice supported staff to gain new skills, by offering flexible working patterns and protected time for learning.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y

Explanation of any answers and additional evidence:

- The practice's vision and values were displayed in the practice and staff behaviours and actions reflected the practice's patient-focused approach.

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.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There had been a period of settling into new roles and overall staff felt they could raise issues of concern with a member of the management team. For example, if changes were proposed that staff felt could not be delivered efficiently and safely, they made suggestions to improve the approach and these views were listened to. • The practice had ensured their regular agency nurse was retained for four months after they employed a new lead nurse, to support a safe handover. 	

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Since the last inspection, the new practice manager has implemented a revised staff structure, with defined roles for staff and protocols for different clinical and non-clinical activities. For example, the practice planned for two receptionists to be on duty at all times. • Staff were clear that they worked within their skills and competencies. 	

- Staff said they understood each others roles and there were appropriate systems for managing tasks and workflow, with written protocols to follow.
- Staff were trained to cover for each other when on leave.
- Clinical staff held morning meetings to share updates and there was a programme of meetings for reception staff, clinical staff and partners.
- Leadership roles had been implemented or were planned pending appropriate training.
- The practice had a management system which prompted when updates were needed, for example in relation to staff training and policies.

Managing risks, issues and performance

There were improved processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	P
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • At the last inspection we found some actions identified previously had not been addressed, and we also noted risks associated with information governance, when staff left their computers. The practice had failed to display its CQC rating on its website. • For this inspection, we found the shortfalls identified previously had been addressed. There had been successful staff recruitment to improve workforce resilience, staff were very clear about the importance of confidentiality and data security and issues with signing PSDs and managing safety alerts had been addressed. • The practice manager identified, highlighted and supported the practice partners in managing the risks associated with the practice. These were discussed at the senior management meetings, and where appropriate at partner meetings. • Although there had been some staff meetings in the past year, the frequency of meetings had been disrupted due to COVID-19. Clinical meetings were generally held monthly, and included actions to take forward. These did not always follow a standard agenda, to ensure topics such as risks, incidents and complaints were included for discussion, to promote reporting and learning. Nurses meetings had been re-established in October 2021, with the new lead nurse in place and a redefining of roles and responsibilities. • The meetings with outside agencies such as community nursing services were less frequent and had not been fully reinstated with the other stakeholders. • At the last inspection, we found there had not been a systematic programme of clinical and internal audit. Despite the impact of COVID-19 and staff changes, the practice had completed some audits since the last inspection. These included clinical audits relating to medicines management, as required by the clinical commissioning group, as well as an audit of infection 	

rates following minor surgery and two infection prevention and control audits. Any actions identified from these audits had been completed.

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had set up triage-first at the onset of the pandemic, as required by the Department of Health and Social Care (DHSC). The initial triage was completed by reception staff, who referred to a set of questions to identify the needs of each patient. If the patient required a clinical consultation, the receptionists organised a call back from a member of the clinical team. If urgent or involved a child, this was prioritised for a prompt response. The practice GPs offered face to face consultations and carried out home visits when the need was identified. The practice had installed a new phone system which meant patients had improved messaging about waiting times. At the time of the inspection, non-urgent consultations were offered the same week, or into the early part of the following week, and patients could book appointments in advance. Appointments were mostly requested by telephone, with a few requests made electronically. The GPs continued to offer home visits, in particular where patients were house-bound. The practice could also use the services of a nurse within the PCN to support patients at home with wound management for example. The administration staff had reviewed a range of patient registers, including those who were vulnerable. At the start of the pandemic, they made regular calls to those known to be at risk, to check they were managing. Infection control procedures had been increased in response to COVID-19, to keep patients and staff safe. Staff felt confident these had been effective and the practice had undertaken individual risk assessments to support each staff member. Staff worked at the practice, and only at home by exception. In these circumstances, the practice provided a laptop for them to use. The practice was proud of the measures they had taken to 	

protect staff and patients from infection, and that staff had not contracted COVID-19 whilst working at the practice.

- Staff told us they had been well looked after during the COVID-19 pandemic, and they had worked well together as a team.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • At the last inspection we identified a breach of Regulation 17, in relation to information governance. We observed staff left their computers unattended on several occasions, with their smart card still inserted. • Since the last inspection, a revised system had been implemented to provide a high level of information security. There was a written protocol and all staff were aware of the importance of removing their smart cards and logging off securely when leaving their desks. They said this was strictly observed. The practice manager also undertook ad hoc audits to ensure staff complied with information governance. 	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y

The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Information about how patient information is used and stored was displayed in the practice waiting room and on their website. The policy relating to the security and confidentiality of patient data that had been reviewed in July 2021. The practice had developed a form for patients to sign should they wish a third party, such as an insurance company, to have information about their medical records. There were systems to ensure this process was managed in line with patients' expectations. Staff explained how they ensured they did not voice out loud any patient identifiable information when they spoke with patients at reception. 	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group (PPG).	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Although there had been some staff meetings in the past year, there had been some disruption due to COVID-19. Clinical meetings were generally held monthly, and included actions to take forward. Staff views had been considered when changes were initiated, for example in the time required for reviews of patients with diabetes. The practice had forms for patients to complete and a box to collect their feedback in reception. Due to COVID-19, there had not been many returned. 	

Feedback from Patient Participation Group.

Feedback
The PPG reported they had good links with the practice manager and told us that ad hoc feedback indicated the practice was providing a good service for patients. As a result of the COVID-19 pandemic, the PPG had not been proactive in seeking patient views or providing improvement support to the practice. The PPG aimed to resume these activities when the membership had greater confidence in meeting collectively. Members of the PPG had supported the COVID-19 vaccine programme for the practice's patients and had identified areas to focus on in 2022.

Continuous improvement and innovation

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

	Y/N/Partial
There was a focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff were supported to develop new skills and introduce improved ways of working. This included to gain additional qualifications. They were encouraged to suggest new ideas and new ways of working. For example, the practice had adopted a communication tool to use should a patient need to be transferred to emergency services, as proposed by the lead nurse. This was the widely recognised 'SBAR Tool', where details of a patient's Situation, Background, Assessment, and Recommendations for further care are recorded on a template and passed to emergency services. The practice had also made changes to the way it administered the flu vaccinations, in response to learning and reflection from an incident. • The practice had effective systems for reviewing patient registers and setting up new registers in response to changes identified need. For example, they used a register of housebound patients to help monitor their care during the COVID-19 pandemic and a register of patients with a high body mass index to aid signposting and referral to dietician services. They had also initiated a new register of cancer patients, which included patients with skin cancers. These registers were reviewed monthly to guide patient reviews. • A new traffic light tool had been introduced to improve the management of test results. • The practice was proud of its patient-focused approach, and its response to COVID-19 in being able to maintain regular health checks and on-the-day clinical triage. 	

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.
- 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.
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- % = per thousand.