

Care Quality Commission

Inspection Evidence Table

Regent Square Group Practice (1-559800210)

Inspection date: 27 and 28 June 2022

Date of data download: 07 June 2022

Overall rating: Good

We inspected the practice on 11 February 2020 and rated the practice requires improvement overall and for the provision of safe and well-led services. A requirement notice was issued for a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities). We followed up the enforcement action with an announced focused inspection on 26 May 2021. We found that the practice had made improvements in relation to the breaches in regulation, however we identified other areas of concern. The practice was rated as requires improvement overall, inadequate for the safe key question and requires improvement for the effective key question. It was rated as good for the provision of caring, responsive and well led services.

We inspected in June 2022 and saw the practice had made improvements and is now rated Good overall. We carried forward the ratings from the last inspection of good for caring and responsive.

Safe

Rating: Good

When we inspected the practice on 11 February 2020, we rated the practice as requires improvement for providing safe services due to gaps in fire safety and safeguarding training, not all patient group directions (PGDs) were up to date, there was no risk assessment for emergency medicines and two healthcare assistants shared a room to deliver a phlebotomy service. An appropriate risk assessment had not been carried out to ensure discussions about care treatment and support only took place where they could not be overheard.

At the inspection in May 2020 we rated the practice as inadequate for safe services because:

- We found that improvements had been made in relation to the previous breaches of regulation. However, we found additional areas of concern. The practice did not have effective systems for the appropriate and safe use of medicines, including medicines optimisation.

At the inspection in June 2022, we saw the practice had made significant improvements, specifically around the safe management of medicines and is now rated as good for safe services.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<ul style="list-style-type: none"> Four members of staff completed feedback forms as part of this inspection process and confirmed they knew how to access policies and procedures. All staff were up to date with safeguarding training. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>At the inspection in My 2021, we found:</p> <ul style="list-style-type: none"> Other than for one nurse, there was no record of up to date vaccinations and immunisation training (the practice manager confirmed this was done at target training sessions). Evidence was requested, but not submitted by the practice. There were systems to ensure the registration of clinical staff was checked on recruitment but there was no evidence they were regularly monitored to ensure they remained current. The practice manager told us the checks were completed, but they were not recorded. The last check we saw was for 2015. The practice manager agreed to document the checks in future. Following the inspection, the practice manager confirmed a system was in place. <p>At the June 2022 inspection, we found:</p> <ul style="list-style-type: none"> There was a record in place of staff vaccinations and immunisations training. There was a system in place to record and monitor clinical staff's registration. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 22/01.2022	Y
There was a fire procedure.	Y

Date of fire risk assessment:22/10/2021 Actions from fire risk assessment were identified and completed.	Y
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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:	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>At the inspection in May 2021, we found:</p> <ul style="list-style-type: none"> • Although infection prevention and control (IPC) audits were being completed, they were not always timely, for example, environmental cleanliness audits were completed in August 2020, February 2021 and May 2021. The audit said it should be completed weekly. The decontamination of equipment audit was completed April 2020, November 2020 and April 2021. The audit said it should be completed monthly. The practice manager agreed the frequency of the audits would be reviewed with the IPC lead. • We saw some of the décor and fixtures and fittings may not be able to be cleaned effectively. For example, in the healthcare assistants (HCA) consulting/treatment room the flooring was worn and stained and needed replacing and some paint work in a GP consulting room was damaged. The practice manager confirmed this was being addressed. We also discussed the practice developing a five-year refurbishment plan. • A written risk assessment for IPC in relation to Covid-19 was unavailable on the site visit and not submitted as part of the inspection process. However, the practice manager told us what systems they had in place to minimise risk and we also observed these. Systems included provision of hand sanitisers, screens at reception, ventilation and personal protection equipment. <p>At the June 2022 inspection, we found:</p> <ul style="list-style-type: none"> • IPC audits were completed weekly as per the practices IPC policy. • The practice had a refurbishment plan in place, this included both clinical and non-clinical areas. Clinical areas had been prioritised and were due to be completed by December 2022. The practice had made good progress, we observed two treatment rooms had been completely refurbished and two extra consultation rooms had been created. They said they would continue to risk assess the facilities, should treatment rooms need refurbishing sooner. 	

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.	N/A
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
<ul style="list-style-type: none"> All non-clinical staff were trained and skilled in various areas to ensure continuity and work on a rotational basis. They also worked part time for flexibility and to cover annual leave and sickness absence. All non-clinical staff had received training to recognise the signs of sepsis. 	

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.	P
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<ul style="list-style-type: none"> As part of the inspection we reviewed the number of tasks that required action. We saw 887 documents, going back to April 2022. We were informed the documents had been reviewed by admin and tasked to someone else (e.g. to GP, pharmacist and actioned) but remained unfiled. The practice agreed to address this immediately. This was logged as an incident and a copy was submitted after the inspection. They have revised the document filing policy which has simplified the process and the workflow will be monitored weekly by all GPs and discussed at the partners meeting. After the inspection the practice submitted evidence the documents had been filed. We also saw 187 blood results had not been checked. The oldest dating from March 2019. The practice were asked to check the historic ones as a priority. This was logged as an incident by the practice and a copy was submitted after the inspection. All 22 historic results were for specimen errors and action had already been taken, but not filed. All the tests were reviewed by the practice and they confirmed they had already been actioned. The practice confirmed blood tests will be monitored weekly by all GPs and discussed at the partners meeting. 	

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) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.95	0.82	0.79	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	9.3%	6.3%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)	6.80	5.30	5.29	Variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	200.8‰	162.2‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.90	0.37	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	4.2‰	3.8‰	6.8‰	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
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

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	P
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.	P
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	NA
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	NA
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.	NA
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>At the inspection in May 2021, we found:</p> <ul style="list-style-type: none"> • The authoriser had signed the Patient Group Directions (PGDs) before some staff had sight of them in three of the 12 viewed. The practice manager agreed all staff would sign to say they were competent before the PGD was authorised. Following the inspection, the practice manager confirmed a system had been implemented. • There was no stock record for some medicines, such as local anaesthetic, an injectable anti-inflammatory, various eyedrops, etc. Following the inspection, the practice manager confirmed a system had been implemented. • There were no records of checks for the oxygen cylinders. We were told visual checks were completed daily but not recorded. The practice manager agreed to document. • There were some systems in place to store blank prescriptions safely. We saw prescriptions were stored in one GP consulting room in an unlocked cupboard and printer although they were in a locked room. It is not advisable to leave the forms in an unlocked cupboard/printer. • There was no evidence of monitoring high risk medicines. For example, we reviewed data for a high-risk medicine used to prevent blood clots. 244 patients had been prescribed this class of medication, 184 patients (75%) had not received the required monitoring. We also reviewed data for a high risk medicines prescribed to reduce high blood pressure. We saw 227 patients had not received annual blood tests. The provider told us that these patients would be reviewed with immediate effect. 	

- There was no evidence of oversight of prescribing for Disease Modifying Anti-Rheumatic Drugs (DMARD). We saw no evidence in patient records that the prescriber had checked records for patients prescribed methotrexate, and recorded monitoring was up to date prior to issuing a prescription. 24 patients had been prescribed this medication and 17 patients (71%) had not had any monitoring of their bloods. We also looked at records of patients who had been prescribed another DMARD medication, Azathioprine. Four patients had been prescribed the medication, we reviewed three patient records (75%) and saw no evidence patients had been monitored. The provider explained blood test results were recorded and monitored by secondary care. There was no evidence results were reviewed by the practice as the results were not recorded in the patient's records. The provider told us that these patients would be reviewed with immediate effect.
- Following this inspection, we asked the practice for confirmation patients had received a review and evidence of action they had taken regarding monitoring of high risk medicines and oversight of prescribing for DMARDS and no evidence was submitted.

At the inspection in June 2022, we found:

- The practice had a record of all the health professionals authorised to practice under PGDs. Health care professionals had recorded an agreement to follow the PGD and these had been authorised.
- There was a stock record for all medicines.
- We saw records to demonstrate the defibrillator and two oxygen cylinders were checked.
- There were systems in place to store blank prescriptions safely.
- The practice had made improvements since the last inspection, through proactively reviewing medicines management via routine clinical searches, to ensure patients were reviewed and monitoring was effective. Monthly searches were completed for patients on high-risk drugs who had outstanding monitoring for example patients on medication to treat high blood pressure and heart failure and blood thinners. Patients were invited for a review and tests.
- They had developed and implemented policies and protocols for medications. For example, rheumatoid arthritis protocol, anticoagulant medications protocol, repeat medication protocol, and altering doses policy.
- As part of this inspection, we completed clinical searches of patients on a high risk medication. 68% of patients on potassium sparing diuretic (medication to prevent low levels of potassium) had received monitoring of blood tests every six months. We reviewed five patient records and three patient records were overdue blood tests. The practice agreed to monitor the register of patients and provide only short term prescriptions if patients do not attend.
- Clinical searches showed good management of patients on Methotrexate (anti-rheumatic medication). We reviewed five patient records, and all had received appropriate monitoring. Best practice is to specify the dose of medicine prescribed stating the day of week to be taken, we saw two records which did not specify this. The practice agreed to do this.
- Medication reviews were carried out on patients on repeat medicines. Of the five records we reviewed, two were well documented. However, three lacked detail of what was discussed during the review. The practice modified the template after the inspection. The practice has also improved the system of annual medication reviews, this included running monthly searches for patients whose birthday falls within that month and a task was sent to the GP to action.
- We reviewed five patient records for medication usage for gabapentinoids (a medication used to treat neuropathic pain and for seizure control in some people with epilepsy). Two patients had not received a medication review.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong/.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	13
Number of events that required action:	13
<ul style="list-style-type: none"> We saw evidence that incidents were discussed at the practice meetings and staff could provide examples of incidents and lessons learned. 	

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

Event	Specific action taken
Incorrect new medication dosage	To be checked by clinician and pharmacist.
Missed telephone appointment	Apology given. Another appointment was offered. Staff reminded of importance of checking patients' details.

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>At the inspection in May 2021, we found:</p> <ul style="list-style-type: none"> We saw examples of actions taken on recent alerts. However, from our system searches during this inspection we saw the practice did not routinely check historical alerts. We saw two patient safety alerts whereby patients had not been informed of the risks of the medication. For example, contraindications of a medicine used to lower blood sugar in adults with type 2 diabetes, a medicine used to treat high blood pressure and one used to lower cholesterol being prescribed together. The provider told us that these patients would be reviewed with immediate effect. <p>At the inspection in June 2022, we found:</p> <ul style="list-style-type: none"> Safety alerts were received by a designated reception email, the pharmacist would disseminate to relevant staff for either information or action. All applicable safety alerts were discussed at the partners meeting. We saw examples of actions taken on recent alerts. 86% of patients receiving medication for easing the symptoms of an overactive bladder had received a blood pressure check within a year. We reviewed five patient records and two patients were overdue a blood pressure check. 	

Effective

Rating: Good

When we inspected the practice on 11 February 2020, we rated the practice as good for effective and for all population groups.

Following the inspection in May 2021 we rated the practice as requires improvement for effective and requires improvement for the following population groups; people with long term conditions, working age people, children, families and young people and people whose circumstances make them vulnerable because:

- Patients' needs were assessed, but care and treatment were not always delivered in line with current standards and evidence-based guidance in relation to reviews of patients with long term conditions and a learning disability.
- Some performance data was below local and national averages and evidence overtime showed the practices attainment had been declining pre-covid in relation to cancer screening and childhood immunisations.
- The practice did not routinely review through quality improvement the effectiveness and appropriateness of the care provided in order to provide effective, safe care.
- Some performance data was below local and national averages and evidence overtime showed the practices attainment had been declining pre-covid in relation to cancer screening and childhood immunisations.

At the inspection in June 2022, we saw the practice had made improvements and is now rated as good for effective services.

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	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
<p>At the inspection in May 2021 we found:</p> <ul style="list-style-type: none"> We saw evidence of registers for people with a learning disability, mental health condition, long term conditions, palliative, carer etc. However, there was no clear evidence of learning disability checks. <p>At the inspection in June 2022, we found:</p> <ul style="list-style-type: none"> There was a learning disability register with a nominated lead who was responsible for reviewing. <p>In addition, we found:</p> <ul style="list-style-type: none"> One of the new GP partners had a specialist interest in sexual dysfunction and menopause and worked at a clinic in Doncaster to offer assessment and treatment for patients suffering from a wide variety of sexual difficulties and testosterone deficiency. The GP could signpost and refer patients to this service. 	

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

At the inspection in May 2021 we rated this population group as requires improvement because we found care and treatment were not always delivered in line with current standards and evidence-based guidance in relation to reviews of patients with long term conditions.

Some patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. However, we reviewed data for a high-risk medicine used to prevent blood clots. 244 patients had been prescribed the medication, 184 patients had not received the required monitoring. We also reviewed data for a high-risk medicine prescribed to reduce high blood pressure. We saw 227 patients had not received annual blood tests.

At the inspection in June 2022, we found:

- As part of our inspection, we conducted a series of additional searches on patient records to review the practice's procedures for the management of patients with long term conditions. We found patients with long-term conditions were mostly offered a structured annual review to check their health and medicines needs were being met and for patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- One search reviewed the management of patients with asthma who had been prescribed two or more courses of rescue steroids within the last 12 months. We reviewed five patients' records, which showed four patients had received an annual asthma review within the last 12 months. There was a lack of follow up to check response to the treatment within a week of an acute exacerbation of asthma in four cases. The practice acknowledged they needed a better system and would develop a new policy and book patients in for a follow up.
- A second search reviewed the monitoring of patients with a thyroid condition who had not had a thyroid function test in the last 18 months. Our search identified of the 308 patients who required monitoring two patients had not received an appropriate test within this period and had not attended for a review. The practice agreed they would provide only short term prescriptions to encourage them to attend their medication review.
- A third search reviewed the recording of patients diagnosed with diabetic retinopathy; a complication of diabetes caused by high blood sugar levels. Our search identified 717 patients diagnosed with diabetes. Of these, 48 patients last blood sugar test showed high sugar levels. We undertook a detailed review of five patients' records, which showed two patients were overdue a review. The practice explained the patients had been invited, but not attended.
- A fourth search reviewed patients who had chronic kidney disease who had not had their bloods monitored in the last nine months. All five patients reviewed had received appropriate monitoring.
- A final search identified one patient who may have a missed potential diagnosis of diabetes from blood tests. The provider confirmed this would be reviewed.
- Although we identified some concerns in relation to long term condition monitoring the practice was proactive in addressing these immediately which assured us that improvement in this area would be regularly reviewed and sustained. One of the GP partners had been identified as a medicines management lead to further strengthen this area.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.

- 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.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.
- A GP Partner had completed health coaching certification (for healthcare professionals) and was studying towards the British Society of Lifestyle Medicine Diploma, which promotes evidence-based lifestyle interventions. This often facilitates de-prescribing, which is cost-effective, and more desirable to patients. Health coaching and motivational interviewing helps to empower and educate patients, identify their individual health priorities and support strategies for change. The practice, with the support of a volunteer Health and Lifestyle Coach/ Practitioner, were currently in the process of identifying a cohort of patients with Type 2 Diabetes and obesity for the lifestyle intervention pilot.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	97	105	92.4%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	82	95	86.3%	Below 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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	82	95	86.3%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)	82	95	86.3%	Below 90% minimum

(01/04/2020 to 31/03/2021) (NHS England and Improvement)				
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	98	115	85.2%	Below 90% minimum

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

Any additional evidence or comments

At the inspection in May 2021, the practice were aware they had not met the minimum target of 90% for two of the childhood immunisation uptake indicators and were taking action to address this. For example, they held a well-baby clinic on a Thursday afternoon 2.00pm – 3.00pm (walk in) for baby and pre-school children immunisations. They also had flexible appointments after school. A year ago, they ran a list of vaccinations and passed the information to school nurses and health visitors. Babies/preschool children who did not attend were followed up by letter and a phone call. Parents were encouraged to attend the walk-in clinic, but a pre-booked appointment could also be arranged.

At the inspection in June 2022, we found the uptake of childhood immunisations had declined in four of the indicators and the provider had not met the 90% minimum target. The practice had continued to try to increase the uptake by extending the length of the well-baby clinic by 30 minutes. They now have two nurses to deliver the immunisation service. They also sent text reminders to parents with a link to information supporting the importance of vaccinations. If a child did not attend the health visitor was informed.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	67.1%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	74.8%	62.3%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	64.7%	67.5%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	67.3%	48.4%	55.4%	No statistical variation

Any additional evidence or comments

At the inspection in May 2021 the practice said they had extended hours on Wednesdays from 7am until 7pm. They were working with their Primary Care Network to look at offering Saturday morning appointments.

At this inspection we found the uptake for cervical screening had slightly declined from 69% in 2021 to 67% in 2022. The practice said they have a high number of patients who did not attend and were continuing to take action, for example they had extended hours on Wednesdays from 7am until 7pm. They were working with their Primary Care Network to look at offering Saturday morning appointments. They were also looking to establish a surge clinic (at Albion place in Doncaster) 10am – 4pm daily as a primary care network. They also advertised on their social media site the importance of having a test and sent text reminders. Three members of the clinical team had attended ‘behavioral science training’ to increase patient attendance of cervical screening. The practice had adopted the ‘nudge’ techniques (a method to encourage people to make different choices without reducing choices available) and resources.

Monitoring care and treatment

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

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

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

At the inspection in May 2021, the provider told us during the covid pandemic resources had reduced, such as staff sickness and nurses allocated to support the covid vaccination hubs. They said they would prioritise the audit programme. To support the programme they will have access to two pharmacists four days a week within the next couple of weeks/months.

At the inspection in June 2022, we found:

- The practice had completed four single cycle audits which led to improvements.
- An audit of a medication used to prevent or slow down bone thinning (osteoporosis) had been completed to ensure appropriate prescribing and monitoring. The audit highlighted several systems based and clinical practitioner based recommendations and a policy for prescribing the medication.
- An audit on the monitoring of higher-risk adult asthma patients in primary care, who were prescribed six or more salbutamol inhalers (used to relieve symptoms of asthma and chronic

obstructive pulmonary disease (COPD)) annually and currently smoke had been completed. With a recommendation to document the frequency of SABA (asthma inhaler) use in a patient review.

- An audit of patients on medication to relieve indigestion was completed to ensure it was in line with NICE guidelines and patients had received a review and medication had reduced within 12 weeks. Recommendations and improvements were made.
- An audit of primary care management of atopic dermatitis (eczema, a condition that causes the skin to become itchy, dry and cracked) in children was completed. This resulted in adding a more detailed template to be used as well as other recommendations for improvement.

Any additional evidence or comments

The practice had also undertaken numerous searches on their clinical system to ensure patients were reviewed and monitoring was effective. For example, patients who had not attended for bowel screening, with a recommendation to complete the searches six monthly to ensure all patients were identified and action taken. Patients with high blood sugar levels were reviewed for diabetes. A search was run to find patients who were missing an annual blood test for monitoring thyroid, 59 patients were identified and reviewed.

Effective staffing

The practice was able to demonstrate 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
<ul style="list-style-type: none"> • Staff were clear about their roles and responsibilities. • There was a system in place to monitor staff training and all staff were up to date with their training, including sepsis. 	

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-centered care when they moved between services.	Y

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

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
<ul style="list-style-type: none"> During our review of five patients records we found two Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms coded on the system, but the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) had not been scanned on to the system. 	

The practice agreed to complete a search to identify where any ReSPECt forms maybe missing and obtain and scan on to the patient's records.

Well-led

Rating: Good

At the last inspection in May 2021, we rated the provider as good.

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
<ul style="list-style-type: none"> The practice had expanded the partnership since the last inspection. They had four new GP partners in addition to three existing partners and an additional nurse. The practice had succession plans in place. They were also supported by a full time pharmacist. Staff said they felt very supported, management were always approachable and open. As a team they always helped each other out and strived to give the best service to patients. They said it was an excellent team and it felt like a family. 	

Vision and strategy

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

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

Culture

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

	Y/N/Partial
There were arrangements to deal with any behavior 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
<ul style="list-style-type: none"> All staff were up to date with equality and diversity training. The practice said they always appreciated staff and would acknowledge and thank them where appropriate. They also accommodated flexible working where possible. 	

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

Source	Feedback
Staff feedback forms	Staff spoke positively about working at the practice and how very supportive it was and how well they worked together. They all supported each other to provide a good service to patients and to help each other.

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
<p>At the inspection in May 2021 we found:</p> <ul style="list-style-type: none"> Staff knew how to access policies and procedures. There was a system to monitor staff training and all staff were up to date. The PGDs had been reviewed, but the authoriser had signed them before some staff had sight of them in three of the 12 viewed. Staff told us they were clear on their roles and responsibilities in relation to chaperoning and what to do in the event of a medical emergency. <p>At the inspection in June 2022, we found:</p>	

- The practice had a record of all the health professionals authorised to practice under PGDs. Health care professionals had recorded an agreement to follow the PGD and these had been authorised.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>At this inspection in May 2021 we found:</p> <ul style="list-style-type: none"> • The practice had a system in place to monitor staff training. • All staff had received annual appraisals. • An emergency medicine risk assessment had been completed. However, the practice did not keep a stock record for some non-emergency medicines. • Staff told us they were aware of the business continuity plans and knew how to access them. • Audit activity had declined (we saw one single cycle audit) since the last inspection. They said they will prioritise the audit programme. <p>At this inspection, we found:</p> <ul style="list-style-type: none"> • There was a stock record for all medicines, including non-emergency. • The practice proactively reviewed and had improved medicines management through routine clinical searches, to ensure patients were reviewed and monitoring was effective. Monthly searches were completed for patients on high-risk drugs who had outstanding monitoring for example patients on medication to treat high blood pressure and heart failure and blood thinners. Patients were invited for a review and tests. • They had developed and implemented policies and protocols for medications commonly used in people with rheumatoid arthritis protocol, anticoagulant medications, repeat medication, and altering doses. • Audit activity had significantly improved and had led to improvements and policy changes. 	

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

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	P
<p>At the inspection in May 2021 we found:</p> <ul style="list-style-type: none"> An emergency medicine risk assessment had been completed. However, the practice did not keep a stock record for some non-emergency medicines. <p>At this inspection, we found:</p> <ul style="list-style-type: none"> Records were in place for emergency and non-emergency medicines. <p>In addition we found:</p> <ul style="list-style-type: none"> Upon review of the practices significant events record there had been an unexpected death of a patient whilst receiving care at the practice in April 2022. Whilst this demonstrated learning and reflection, the practice did not notify the Care Quality Commission as required. The practice were informed of the requirement and submitted the notification immediately. 	

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

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.	N
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>At the inspection in May 2021, we found:</p> <ul style="list-style-type: none"> The practice's patient participation group (PPG) meeting had been paused during the pandemic, however, they retained a good relationship and communication with them. They were looking to restart the PPG meetings at the end of June 2021. The practice said they will resume patient surveys within the next few months and currently they received patient feedback through a text messaging service and their website. <p>At the inspection in June 2022, we found:</p> <ul style="list-style-type: none"> Primary Care Doncaster were raising awareness of PPGs and looking at establishing a forum. 	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had expanded their workforce since the last inspection and had aspirational plans for the future, for example becoming a training practice. A healthcare professional had developed a pack to support new mums after their six week review, it included a contraception leaflet, local mum and baby support in Doncaster, recommended 'Apps' for new mums, video link to physio pelvic floor exercises, local feeding support, mental health support and postnatal care advice. As part of a primary care network they were working collaboratively to organise supportive groups for patients with long term conditions, such as diabetes and weight management including weekly walks. Three members of the clinical team had attended 'behavioral science training' to increase cervical screening uptake. The practice had adopted the 'nudge' techniques (a method to encourage people to make different choices without reducing choices available) and resources. A neighboring practice hosted a diagnosis and management of Chronic Obstructive Pulmonary Disease (COPD) session/meeting for patients and staff. 19 patients attended and the practice received positive verbal feedback. All patients said they would recommend these types of sessions to others as found them to be very informative and made them think more about their own management. 	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

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

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

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

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

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

Glossary of terms used in the data.

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