

Care Quality Commission

Inspection Evidence Table

DMC Chadwick Road

(1-565650650)

Inspection Date: 8 August 2023

Date of data download: 28/07/2023

Overall rating: Requires Improvement

At the last rated inspection in October 2021, the practice was rated Requires Improvement overall. A subsequent unrated inspection in May 2022 resulted in Requirement Notices for Regulation 12: Safe care and treatment and Regulation 17: Good governance.

At this inspection in August 2023 the practice remains rated as Requires Improvement due to concerns identified with:

- Recruitment checks for locum staff.
- DNACPR decisions.
- Monitoring of patients with long term conditions.

Safe Rating: Good

At the last rated inspection in October 2021, the practice was rated Requires Improvement for providing safe services because:

- The practice's clinical record system did not alert staff of all family and other household members of children that were on the safeguarding register.
- Safeguarding training for some staff members was not in accordance with national guidance.
- The provider was unable to demonstrate all safety alerts had been responded to.

At this inspection in August 2023, we found some improvements had been made.

- The practice's clinical record system alerted staff of all family and other household members of children that were on the safeguarding register.
- Staff had completed safeguarding training appropriate to their role.
- Safety alerts had been responded to appropriately.

However, we also identified concerns.

- We did not see evidence that all appropriate recruitment checks had been completed for staff employed through locum agencies.

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
<p>Explanation of any answers and additional evidence:</p> <p>At our last rated inspection in October 2021, we found that not all staff had completed safeguarding training appropriate to their role. The practice's computer system did not alert staff of children that were on the risk register as well as family and other household members of children on the risk register.</p> <p>At this inspection in August 2023, we found that improvements had been made.</p> <p>We looked at the training records of five staff members and found that all staff were up to date with safeguarding training appropriate to their role.</p> <p>The practice had a safeguarding register. The practice's computer system alerted staff of children that were on the risk register as well as family and other household members of children on the risk register.</p> <p>There were notices around the practice and in clinical rooms advising patients that chaperones were available. We saw that staff who acted as chaperones were trained for the role.</p> <p>We reviewed the recruitment records of 5 staff members and found 4 staff members had a DBS certificate or a completed self-declaration form within the last 3 years. One member of staff had a DBS over 3 years old but did not have a completed self-declaration form on file. After the inspection, the provider wrote to us with evidence of a self-declaration form for this staff member.</p>	
Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial

Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The provider worked with a recruitment agency who supported the practice through recruitment of locum staff in line with the practice's recruitment policy. The provider showed us evidence of communication with the agency which stated all locums had up to date documents. However, it was unclear which documents had been checked. The provider did not have a process to check which documents had been obtained prior to employment. For example, we did not see evidence the provider had seen satisfactory references for 2 locum clinical staff prior to commencing employment. At a previous inspection of another of the provider's locations in September 2022, we found similar concerns relating to recruitment documentation for locum staff.</p> <p>We looked at the immunisation records of 5 staff members. We found no record of tetanus, diphtheria, or polio vaccination for 1 member of clinical staff. We shared our findings with the provider. We were sent evidence of these vaccinations following our inspection.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: May 2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: 9 November 2022	Y
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The provider had completed a health and safety risk assessment in May 2023. The provider had identified actions that needed to be completed for example, staff needed to complete mandatory training related to health and safety. We were told that all identified actions had been completed. However, we reviewed the training records of 5 staff members and found that 1 staff member had not completed training in fire safety, mental capacity act, equality and diversity and sepsis awareness. We shared our findings with the provider. We were sent evidence that this training had been completed following our inspection.</p> <p>The provider had conducted a fire risk assessment on 9 November 2022. The questionnaire asked if personal emergency evacuation plans (PEEPs) had been completed. The provider had answered "not applicable" to this question as there were no staff members in the practice with a disability. However, the provider had not considered that there may be visitors to the practice who needed assistance to exit the building in an emergency. After the inspection, the provider sent us a copy of their personal and general emergency evacuation plan policy. The policy stated that a general emergency evacuation plan (GEEP) should be used in premises where members of the public visit. This plan was relevant to visitors to the building who have a disability or mobility impairment and may not be able to evacuate unaided. The policy also stated that an up to date GEEP would be in place for all visitors to the premises. However, the practice's fire evacuation plan did not give directions on how visitors with a disability or mobility impairment would be supported to evacuate the building in an emergency, nor was this considered at the practice's most recent fire drill.</p> <p>Records showed that calibration testing of equipment and portable appliance testing (PAT) had been carried</p>	

out within the last 12 months.

The provider had a fire evacuation plan, completed testing of the fire alarm system and carried out fire drills. The most recent fire drill took place on 28 June 2023.

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.	Y
Date of last infection prevention and control audit: 5 April 2023	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> <p>The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. We looked at the training records of 5 staff members and saw they had received appropriate training in infection prevention and control (IPC).</p> <p>Records showed the provider had completed an IPC audit which identified 2 actions that the provider needed to take. For example, staff members did not have access to occupational health services. We saw that all identified actions had been completed or had dates for completion.</p>	

Risks to patients

There were 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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>We looked at the records of 2 clinical staff employed through a locum agency. Both staff members had begun working at the practice in the last 12 months. We saw evidence that only 1 of these staff members had received an induction to the practice.</p>	

We looked at the training records of 5 members of staff and found all had completed basic life support training.

The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Posters with signs and symptoms of suspected sepsis were displayed in clinical rooms and the administration office. We looked at the training records of 5 staff members and found there was no record that 1 member of clinical staff had received training in the recognition and management of patients with potential sepsis. We shared our findings with the provider. Evidence that this training had been completed was shared with us following our inspection.

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
Explanation of any answers and additional evidence:	
Review of patient records identified that care records were managed in line with current guidance.	
Referrals were appropriate and managed in a timely manner.	

Appropriate and safe use of medicines

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

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to	0.63	0.69	0.91	Tending towards variation

31/03/2023) (NHSBSA)				(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). (01/04/2022 to 31/03/2023) (NHSBSA)	5.6%	8.0%	7.8%	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 (01/10/2022 to 31/03/2023) (NHSBSA)	6.46	5.48	5.23	Tending towards variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	42.7‰	73.4‰	129.9‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.19	0.37	0.55	Variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	3.7‰	4.8‰	6.8‰	Tending towards variation (positive)

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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective 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 and Improvement Area Team Controlled Drugs Accountable Officer.	Y

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.	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.	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>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>We reviewed patients prescribed medicines requiring monitoring. We found that patients prescribed methotrexate; and patients prescribed ACE inhibitors or Angiotensin II receptor blockers were monitored in line with best practice guidance.</p> <p>We saw there was an inventory of emergency medicines held and regular monitoring took place. The provider held medical oxygen and a defibrillator on site, these were monitored regularly.</p> <p>There were 3 refrigerators at the practice. We saw evidence of regular checking of temperatures. The provider had recorded a significant event where the temperature of 1 of the refrigerators was recorded as being outside of acceptable limits on 2 occasions. The practice's cold chain policy had been followed. This included checking the affected medicines had not been given to patients; placing the affected medicines in quarantine so they would not be used; and reporting the breach to the medicine manufacturers.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	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:	3
Number of events that required action:	3
Explanation of any answers and additional evidence: We saw evidence that significant events were discussed in clinical meetings. All staff members we spoke to or who completed feedback forms told us they were made aware of significant events either in meetings or via email.	

Example of significant events recorded and actions by the practice.

Event	Specific action taken
There was a cold chain breach. One of the refrigerators at the practice recorded temperatures outside of acceptable limits on 2 occasions.	There was an investigation which found that no vaccines had been administered to patients during the breach period. The vaccines were marked as not for use whilst the breach was reported to the vaccine manufacturers. The practice took the manufacturers guidance as to whether the vaccines were still effective and safe to use. The provider also changed their policy so that refrigerator temperatures were recorded more frequently.

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
Explanation of any answers and additional evidence: At our previous unrated inspection in May 2022 and the previous rated inspection in October 2021, the provider was unable to demonstrate that all relevant safety alerts had been responded to. At this inspection in August 2023, we found improvements had been made. We saw examples of actions taken on recent alerts, for example, regarding SGLT-2 inhibitors. We reviewed the records of 5 patients prescribed this medicine and found that all had been informed of the risks associated with this medicine as per best practice guidance.	

Effective Rating: Requires Improvement

At the last rated inspection in October 2021, the practice was rated Requires Improvement for providing effective services because:

- Patients were not always coded appropriately or monitored in line with evidence-based guidance.
- Patients with a potential missed diagnosis of Chronic Kidney Disease (stages 3, 4 or 5) and patients with a potential missed diagnosis of diabetes, were not monitored in line with evidence-based guidelines.
- Child immunisation performance and uptake was below the national target.
- There was limited evidence of quality improvement activity including clinical audits.
- Staff did not have regular appraisals.

At this inspection in August 2023, we found improvements had been made. In particular:

- Patients with a potential missed diagnosis of Chronic Kidney Disease (stages 3, 4 or 5) and patients with a potential missed diagnosis of diabetes, were monitored in line with evidence-based guidelines.
- There had been improvements to child immunisation performance, 4 out of 5 indicators now met the 90% minimum target for uptake.
- We saw evidence of quality improvement through clinical audits.
- Staff received regular appraisals.

However, we also identified concerns. We have rated the practice as Requires Improvement for providing effective service because:

- Do not attempt cardiopulmonary resuscitation (DNACPR) decisions were not reviewed at appropriately frequent intervals.
- Improvements were required in the monitoring of some patients with long term conditions.

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 sometimes delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools. However, improvements were needed to the monitoring of patients with long term conditions.

	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.	Partial
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
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence: Patients with chronic kidney disease (CKD) and hypothyroidism were receiving relevant reviews. The provider had an action plan to improve the monitoring of patients with asthma, diabetic retinopathy and those prescribed gabapentinoids.	

Effective care for the practice population

Findings

- 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 considered the needs of those whose circumstances may make them vulnerable. The practice held monthly meetings with the palliative care team.
- 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.

At our previous inspection in October 2021, we found patients identified as having potential missed diagnoses of diabetes or CKD had not been followed up appropriately or informed of their diagnosis.

At this inspection on 8 August 2023, our searches identified no patients as having potential missed diagnosis of diabetes. We identified 1 patient as having a potential missed diagnosis of CKD Stage 3, 4 or 5. We found this patient had been monitored in line with best practice guidance.

We looked at 5 medicine reviews. We found 4 of these reviews were completed to a high standard. We found 1 review contained limited information. We shared our findings with the provider. The provider showed us evidence that the patient had now received an appropriate detailed review using the relevant templates.

Our clinical searches identified 43 patients were prescribed gabapentinoids (medicines used to treat epilepsy or

nerve pain). We saw that 15 of these patients had possibly not had a review in the last 12 months. We reviewed 5 of these patients and found 4 patients were overdue a medicines review. We shared our findings with the provider. The provider was able to demonstrate that the 4 patients identified has now received structured reviews. The provider also had an action plan for the clinical pharmacist to review all patients prescribed this medicine.

Our searches identified that 19 patients had been prescribed 2 or more courses of rescue steroids. We reviewed the records of 5 of these patients. Between these patients, there were 11 occasions of an acute exacerbation of asthma. Only 1 occasion resulted in a follow up within a week of acute exacerbation. On 4 occasions, an adequate assessment had not been undertaken at the time of prescribing. Two patients were also overdue their annual asthma review. We shared our findings with the provider. After our inspection, the provider told us the practice protocol had been updated so that clinicians would book a follow up appointment within the next 7 days at the time of prescribing rescue steroids. The provider planned to arrange a clinical meeting with GPs to discuss inconsistency with assessments and ensure appropriate guidelines were followed.

We saw that patients with hypothyroidism and CKD Stage 4 or 5 were monitored in line with best practice guidance.

We reviewed 5 patients with diabetic retinopathy and found that 1 patient was overdue monitoring tests. We shared our findings with the provider. The provider showed us evidence that the patient had now been scheduled to attend for the appropriate monitoring tests.

Management of people with long term conditions

Findings

- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- 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.
- The provider had produced information videos which could be sent to patients following a diagnosis of a condition, for example chronic kidney disease. The videos contained information about the condition and what patients should expect from the practice in terms of monitoring of their condition and prescribed medicine.

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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	64	70	91.4%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	52	66	78.8%	Below 80% uptake
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	60	66	90.9%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	60	66	90.9%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	58	61	95.1%	Met 95% WHO based target

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

Any additional evidence or comments
<p>Childhood immunisations were carried out in line with the national childhood vaccination programme.</p> <p>NHS England results (published in March 2022) showed that uptake rates were higher than the World Health Organisation (WHO) minimum target of 90% for 4 indicators and below 80% uptake for 1 indicator.</p> <p>The provider told us they were aware of the need to improve child immunisation uptake. They had taken a proactive approach to contacting patients who were due immunisations and placed warning messages on patient notes if there was no response to contact. This was to alert staff that immunisations were due so this could be discussed with parents or carers when attending the practice for other matters. Parents who declined immunisation were sent information from WHO to remind of the importance of childhood vaccinations. The practice offered evening and weekend appointments at the local extended primary care service. Staff were completing a process to remove patients they suspected had moved out of area. The provider expected this would improve their performance figures in this area.</p>

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	42%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	58.7%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened	71.2%	N/A	80.0%	Below 80% target

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). (12/31/2022 to 12/31/2022) (UKHSA)				
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	52.6%	50.9%	54.9%	No statistical variation

Any additional evidence or comments

Published results showed the provider's uptake for cervical cancer screening was below the 80% target for the national screening programme.

The provider told us that in an attempt to increase uptake for cervical screening; they regularly reviewed the updated figures and contacted patients to remind patients of the need to book an appointment; and used opportunistic appointment bookings when a patient attended the practice for other matters. After the inspection, the provider wrote to tell us they had started a text message campaign. Patients whose cervical screening was overdue were sent a text message advising them to book an appointment and sent a link to information on the importance of screening.

As with childhood immunisations, the practice offered evening and weekend appointments for cervical screening at the local extended primary care service.

Data published in March 2023 showed similar results. This data showed the uptake rate for cervical cancer screening was 72.2%.

The practice provided data from NHS England which indicated their performance for cervical cancer screening was in line with other practices in the area.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	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 our last rated inspection in October 2021 and our previous unrated inspection in May 2022, we found limited evidence of quality improvement through clinical audits.	

At this inspection in August 2023, the provider shared 3 two-cycle audits that had been completed over the last 2 years. These audits demonstrated some evidence of quality improvement whilst acknowledging improvements were still required.

For example, the provider had reviewed patients prescribed pregabalin to ensure safe prescribing. Initially, 4 out of 10 patients were identified as prescribed higher doses. The provider identified that to ensure safe prescribing, dosage should be reviewed and reduced where appropriate. The audit was repeated, the provider found that 1 out of 10 patients was now prescribed a higher dose, this had been discussed and was being monitored in line with best practice guidance.

Effective staffing

The practice was able to demonstrate that all 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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>At our last rated inspection in October 2021, we found that not all staff members received regular appraisals.</p> <p>At this inspection in August 2023, we looked at the recruitment records of 5 staff members and all had access to regular appraisals.</p> <p>We looked at the recruitment records of 5 staff members. We looked but could not find evidence that 1 locum member of staff had received an induction.</p> <p>There was a programme of essential training. We looked at the training records of 5 staff members. We could not see evidence that 1 member of staff had completed training in fire safety, mental capacity act, equality and diversity or sepsis awareness. We shared our findings with the provider. We were sent evidence that this training had been completed following our inspection.</p>	

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

	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

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
<p>Explanation of any answers and additional evidence:</p> <p>We saw posters in the practice waiting room which gave information about how patients could manage their own health. For example, support for people with diabetes and information on mental health support.</p>	

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance. However, DNACPR decisions were not always made in line with relevant legislation.

	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.	N
<p>Explanation of any answers and additional evidence.</p> <p>We reviewed 2 patient records where a DNACPR decision had been recorded. This identified that where a DNACPR decision had been recorded, patient views had been sought and respected. We saw there was a clear rationale for the decision that was not discriminatory nor based on assumptions about the person's quality of life. However, the record for 1 patient's DNACPR did not appear to have been reviewed since November 2020. We did not see a planned future date for review. The provider wrote to us after the inspection to tell us that all DNACPR decisions had been reviewed in the last few months. However, we were not provided with evidence of these reviews.</p>	

Responsive

Rating: Good

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	
The layout of the practice meant that all areas were accessible to people using wheelchairs or mobility scooters. A hearing loop was available at reception. Toilets were accessible to people with limited mobility and there were designated baby changing facilities.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm

Further information about how the practice is responding to the needs of their population

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Pre-bookable appointments were available at a local extended access service run by the local Primary Care Network (PCN). This provided GP and nurse appointments between 8am-8pm 7 days a week.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

People were able to access care and treatment in a timely way.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence:</p> <p>There were multiple appointment types available, including face to face and telephone consultations. Patients were able to book appointments in person, on the telephone and online. The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.</p> <p>On the day of inspection, we looked at the practice's appointment system and found the next available face to face appointment with a GP was on 9 August 2023, the next available telephone appointment with a GP was on 9 August 2023, and the next available appointment with a nurse was on 8 August 2023. Appointments were also available each day at the local extended primary care service.</p>	

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
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 (01/01/2023 to 30/04/2023)	77.1%	N/A	49.6%	Significant variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	57.7%	49.7%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	53.8%	50.0%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	75.6%	66.2%	72.0%	No statistical variation

Any additional evidence or comments

All indicators from the national GP patient survey published in April 2022 showed feedback was positive and in line with local and national averages. We saw evidence the provider carried out their own patient surveys.

Source	Feedback
NHS.uk website (formerly NHS Choices)	There were 3 reviews on the NHS website in the last year. These reviews were mixed. Positive comments referred to kind, helpful reception staff. Negative comments referred to difficulty accessing test results.
Experience shared with CQC directly via our website	There was 1 comment received by CQC which referred to difficulty accessing appointments.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	13
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Example(s) of learning from complaints.

Complaint	Specific action taken
A coding error was found on a patient's record	The coding was corrected once discovered. Practice staff identified that the error may also be present on the systems of third-party organisations. The provider contacted the third parties involved to ask them to check the coding on their systems.
A patient complained that they experienced a long wait on the telephone, despite being told they were number 1 in the queue.	This was investigated and found to be an issue with the telephone system. This has been reported and is due to be fixed by the telephone company. This was shared with staff at the practice for awareness.

Well-led

Rating: Requires Improvement

At our last rated inspection in October 2021, we rated the practice as Requires Improvement for providing Well-led services because:

- The provider's processes for managing risks, issues and performance were not always effective. These included risks relating to safeguarding and long-term conditions management, issues related to non-effective clinical audits and a lack of appraisals.

At this inspection in August 2023 the practice remains rated as Requires Improvement for providing well-led services because:

- The provider's processes for managing risks, issues and performance were not always effective. These included risks relating to recruitment of locum staff; identification and action taken for risks relating to fire safety; staff induction; DNACPR records; and monitoring of patients with long-term conditions.

Leadership capacity and capability

There was compassionate and inclusive leadership at all levels, however improvements were needed to ensure the delivery of high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
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:	
The provider told us they were aware that improvements to quality, safety and performance were required. However, action was required in relation to the following:	
<ul style="list-style-type: none"> • Staff recruitment • Review of DNACPR decisions • Monitoring of some patients with long term conditions 	

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
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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
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed the training records of 5 staff members and found that 1 staff member had not completed training in equality and diversity. We shared our findings with the provider. We were sent evidence that this training had been completed following our inspection.</p>	

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

Source	Feedback
Staff interviews and feedback forms	We received 9 staff feedback forms and conducted interviews with staff at the practice. Staff said they felt supported and felt comfortable raising concerns. Staff also commented that although they felt there were sufficient staff at the practice, they would like to see the recruitment of permanent clinical staff members.

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
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence: We looked at 25 governance policies and found these to be up to date.	

Managing risks, issues and performance

The practice did not have clear and 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.	N
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: Our inspection identified that improvements were required in relation to the management of risks in relation to: <ul style="list-style-type: none"> Recruitment of locum staff. Identification and action taken for risks relating to fire safety. Staff induction. DNACPR records. Monitoring of patients with long-term conditions. As result of our inspection action had been taken in relation to the risks of: <ul style="list-style-type: none"> Monitoring of patients with long-term conditions. However, action was still required to demonstrate their systems and processes were effective in the management of risks from: <ul style="list-style-type: none"> Recruitment of locum staff. 	

- Identification and action taken for risks relating to fire safety.
- Staff induction.
- DNACPR records.

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.	Y

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
Staff are supported to work remotely where applicable.	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.	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: The practice had an active patient participation group (PPG) who held meetings with practice representatives approximately every 3 months.	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: Complaints and significant events were used to make improvements. We saw evidence that learning from complaints and significant events was shared with staff. Staff told us they attended meetings where learning was shared.	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **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.