

Care Quality Commission

Inspection Evidence Table

Regent Square Group Practice (1-559800210)

Inspection date: 11 February 2020

Date of data download: 17 December 2019

Overall rating: Requires Improvement

We have rated this practice as requires improvement for the provision of safe, effective and well led services because:

- The practice had not always implemented systems and processes in areas such as recruitment and training, infection prevention and control, patient confidentiality and medicines management to keep people safe and safeguarded from abuse.
- The governance arrangements did not always operate effectively, and the provider did not have clear and effective processes for managing risks, issues and performance.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe improvement

Rating:

Requires

The practice has been rated as requires improvement because:

- The practice had not always implemented systems and processes in areas such as recruitment and training, infection prevention and control, patient confidentiality and medicines management to keep people safe and safeguarded from abuse.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	P*
There were policies covering adult and child safeguarding.	Y

Safeguarding	Y/N/Partial
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Policies were accessible to all staff.	P*
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	P**
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	P***
Staff who acted as chaperones were trained for their role.	P****
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> <ul style="list-style-type: none"> *We saw copies of policies and procedures were kept in reception and in the practice managers office, they were also available electronically on the practices shared drive. However, some staff were vague about how to access policies and procedures. The practice manager agreed to communicate to staff where and how to access policies. Safeguarding was a standing agenda item at weekly GP partners meetings. ** There was a basic system in place to monitor staff training, all training certificates were kept in individual staff files which were reviewed by the practice manager. The practice manager also used quarterly practice in-house training sessions as a prompt to review staff training needs. The practice manager said they would strengthen the system by implementing a training matrix. ***The practice had obtained DBS checks for most staff. One member of staff had not had a recent DBS check or chaperone training and had acted as a chaperone recently. The practice assured us none clinical staff were never alone with a patient and never acted as a chaperone. ****One member of staff had not had a recent DBS check or chaperone training and had acted as a chaperone recently. The practice manager confirmed a DBS check would be completed and non-clinical staff do not act as chaperones, this was the role of healthcare assistants or nurses. The healthcare assistants confirmed they had received chaperone training 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	P*
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff had any necessary medical indemnity insurance.	Y

Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> *The practice had obtained DBS checks for most staff. One member of staff had not had a recent DBS check. The practice manager confirmed a DBS check would be completed. 	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: April 2019	Y
There was a record of equipment calibration. Date of last calibration: April 2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: March 2019	Y
There was a log of fire drills. Date of last drill: September 2019	Y
There was a record of fire alarm checks. Date of last check: February 2020	Y
There was a record of fire training for staff. Date of last training: June 2018	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: June 2019	Y
Actions from fire risk assessment were identified and completed.	Y

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: January 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: November 2019	Y

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
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There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit: January 2020	Y
The practice had acted on any issues identified in infection prevention and control audits.	N*
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> * Required improvements had been identified in the IPC audit for example, there were no hands-free operated taps in the toilets. However, there was no action plan in place on the day of inspection to address this. After the inspection the practice confirmed the action plan had been updated. 	

Risks to patients

Systems to assess, monitor and manage risks to patient safety were not always adequate.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	N*
Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	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.	P*
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Cover for staff absences was in place when needed. ** On the day of inspection, we observed two healthcare assistants shared a room to deliver a phlebotomy service. There was a curtain in the middle of the room to act as a divide. Patients were seen with each healthcare assistant at the same time. The management team explained if patients wished to speak with a clinician privately, they could do so outside of this treatment 	

room. They told us patients had not given any negative feedback or made a complaint relating to privacy and confidentiality. However, this does not always allow patients to speak openly or raise any concerns, in relation to mental health, domestic abuse, etc. In addition, this could be viewed as a breach of confidentiality and the practice had not completed a risk assessment. The practice agreed to review the provision of the phlebotomy service.

- **Staff understood how to activate and respond to the panic alarms. Non-clinical staff had not received training in sepsis. However, they were aware of the process to follow and there was a sepsis identification poster in all rooms.

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
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
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
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

Appropriate and safe use of medicines

The practice had some 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) (01/10/2018 to 30/09/2019) <small>(NHS Business Service Authority - NHSBSA)</small>	1.05	0.94	0.87	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	9.8%	5.7%	8.5%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) (NHSBSA)				
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 (01/04/2019 to 30/09/2019) (NHSBSA)	6.62	5.30	5.60	Tending towards variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	3.89	3.00	2.08	Tending towards variation (negative)

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).	P*
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 structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
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.	N/A

Medicines management	Y/N/Partial
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.	N**
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	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 PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> *The practice had Patient Group Directions (PGDs) in place, however four were out of date. **The practice did not stock all recommended emergency medicines and an appropriate risk assessment had not been carried out to identify a list of medicines that are not suitable for a practice to stock. The practice had a safe system for monitoring high risk medications, for example if blood monitoring was not up to date this was flagged to the appropriate GP. 	

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:	11
Number of events that required action:	3
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Complaints were recorded as significant events. The practice had also received 15 thank you cards from patients. Significant events were discussed at weekly partnership meetings and at practice learning sessions. This allowed staff to contribute, understand and learn from significant events. Some staff could also provide examples of recent significant events 	

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

Event	Specific action taken
Aggressive behaviour towards staff	Discussed with staff. The practice employed security for one month to ensure staff and patients were safe.
High number of repeat medication requests from one patient.	Practice investigated and a safeguarding concern was identified and reported.

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: <ul style="list-style-type: none"> *Safety alerts were received by the practice manager who disseminated to relevant staff for either information or action. Staff were able to describe examples of recent alerts, and how actions had been completed appropriately. All applicable safety alerts were discussed at the partners meeting and nurse's meetings. Both meetings were minuted and shared with staff. 	

Effective

Rating: Good

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y*
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence:	

- *In October 2019 the practice joined the proactive care service pathway, to manage patient care within the patient's usual place of residence, offer person centred care and work collaboratively with external partners and agencies in Doncaster. This service identified complex or frail patients who are supported through patient centred care plans and have regular reviews.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	0.91	0.49	0.74	No statistical variation

Older people

Population group rating: **Good**

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. Patients identified were also discussed at the proactive care meetings,
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication 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.

People with long-term conditions

Population group rating: **Good**

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- 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 atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- The practice had recently introduced a fibromyalgia support group for patients which was led by the salaried GP. This was a coffee morning for patients to share experiences on how they manage their condition and information was also available to support them. They planned to hold further meetings in the future.
- Patients with asthma were offered an asthma management plan.
- The practice held quarterly (multidisciplinary where possible) palliative care meetings.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	86.9%	82.5%	79.3%	No statistical variation
Exception rate (number of exceptions).	19.9% (124)	12.3%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	89.5%	82.9%	78.1%	Tending towards variation (positive)
Exception rate (number of exceptions).	10.8% (67)	9.0%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	76.2%	83.2%	81.3%	No statistical variation
Exception rate (number of exceptions).	18.2% (113)	14.4%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	73.4%	77.0%	75.9%	No statistical variation
Exception rate (number of exceptions).	2.4% (17)	7.6%	7.4%	N/A
The percentage of patients with COPD who	90.4%	91.6%	89.6%	No statistical variation

have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>				
Exception rate (number of exceptions).	17.6% (40)	12.0%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	82.9%	85.0%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.7% (36)	3.5%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) <small>(QOF)</small>	90.8%	91.2%	91.1%	No statistical variation
Exception rate (number of exceptions).	3.4% (6)	4.7%	5.9%	N/A

Families, children and young people

Population group rating: Good

Findings

- The practice had met the minimum 90% target for four of four childhood immunisation uptake indicators. However, they had not met the World Health Organisation (WHO). based national target of 95% (the recommended standard for achieving herd immunity) for four of four childhood immunisation uptake indicators. The practice was aware they were below the national targets and were taking action to address this. For example, they offered immunisations at walk in baby clinic every Thursday, letters, phone calls and text messages.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO
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				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) (01/04/2018 to 31/03/2019) (NHS England)	109	119	91.6%	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) (01/04/2018 to 31/03/2019) (NHS England)	77	85	90.6%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	77	85	90.6%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	77	85	90.6%	Met 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>

Working age people (including those recently retired and students)

Population group rating: Good

Findings
<ul style="list-style-type: none"> 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. Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (31/03/2019 to 30/06/2019) (Public Health England)	73.7%	N/A	80% Target	Below 80% target

Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	71.6%	72.5%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	56.1%	58.3%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) (PHE)	70.4%	65.6%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	56.0%	44.6%	53.8%	No statistical variation

Any additional evidence or comments

- The practice was aware they were below the national targets for cervical screening and were taking action to address this. They used letters, text messaging, recalls, extended hours and opportunistically reminded patients.
- The practice held regular meetings to discuss new cancer diagnoses which included the route of referral and to identify any learning.

People whose circumstances make them vulnerable

Population group rating: **Good**

Findings

- Same day appointments and longer appointments were offered when required.
- 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.

People experiencing poor mental health (including people with dementia)

Population group rating: **Good**

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking'

services.

- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	97.1%	93.6%	89.4%	Tending towards variation (positive)
Exception rate (number of exceptions).	22.2% (20)	18.0%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	97.1%	95.0%	90.2%	No statistical variation
Exception rate (number of exceptions).	22.2% (20)	13.6%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	84.3%	83.6%	83.6%	No statistical variation
Exception rate (number of exceptions).	6.7% (5)	7.5%	6.7%	N/A

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.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	558.2	537.0	539.2
Overall QOF score (as a percentage of maximum)	99.8%	98.4%	96.4%
Overall QOF exception reporting (all domains)	7.0%	6.1%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	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

The practice had completed a two-cycle audit for prescribing pain relief medication. The aim was to reduce the number of patients prescribed this medication. The audits showed a decrease in the prescribing of the medication, which reduced the risk of exposing patients to long term harm.
The practice had completed a two-cycle audit for the usage of antibiotics for a respiratory infection. This had revealed guidance for antibiotic prescribing was not being followed. The re-audit revealed more appropriate use of antibiotics for this condition. Overall showing an improvement in guideline adherence and better antibiotic stewardship.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	P*
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	P**
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	NA
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.	P***
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	Y

their performance was poor or variable.	
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • *One non-clinical staff member had worked outside of their level of competence. For example, they had recently acted as a chaperone without any chaperone training. The practice assured us none clinical staff were never alone with a patient and never acted as a chaperone. • **There was a basic system in place to monitor staff training, all training certificates were kept in individual staff files which were reviewed by the practice manager. The practice manager also used quarterly practice in-house training sessions as a prompt to review staff training needs. The practice manager said they would strengthen the system by implementing a training matrix. We were told mandatory training included CPR, fire safety, infection prevention and control and safeguarding. There were some gaps in staff training. One member of staff had not received fire safety training and they had been in post since November 2018, this had been scheduled. Three non-clinical staff were due to complete safeguarding training. Non-clinical staff had not received sepsis training, but staff were aware of what to do if a patient deteriorated. The practice confirmed after the inspection training would be scheduled. • ***Three clinical staff said they received annual appraisals. One out of two non-clinical staff we spoke with said they had not received an appraisal. We viewed two staff files and there was no record of appraisals in 2019. All staff we spoke to said they felt supported. The practice manager confirmed all appraisals were due in February 2020. 	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
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
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
Explanation of any answers and additional evidence:	

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, tackling obesity.	Y
Explanation of any answers and additional evidence:	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	92.2%	96.0%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.9% (23)	0.7%	0.8%	N/A

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
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence:	

Well-led improvement

Rating:

Requires

The practice has been rated requires improvement because:

- There were no clear responsibilities, roles systems of accountability to support good governance and management.
- The provider did not have clear and effective processes for managing risks, issues and

performance.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had a stable partnership with a low staff turnover. The practice was aware of succession planning, they had a new GP partner, two salaried GPs and an assistant practice manager. • Staff reported that they felt supported, part of a team and management were approachable. • The leadership team were knowledgeable about issues and priorities for the quality and sustainability of services, understood what the challenges were and acted to address them. For example, they had taken on another GP partner to ensure sustainability. 	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had a mission statement displayed in reception. 	

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's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	P**

Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> *The management team had a strong emphasis on staff welfare and encouraged compassionate, inclusive and supportive relationships amongst staff, so they felt respected, valued and supported. They said this was important to delivering high quality patient care. There were processes to support staff and promote their positive wellbeing. For example, the practice were participating in the 'Virgin pulse global challenge' which encouraged increased physical activity. *The practice had a 'ring back' system. Each GP had a ring back list representing their availability that day. Patients requesting a consultation with a GP were placed on the ring back list, with a guarantee to be contacted within 24 hours. Once the list is full, patients are offered to be seen by a different GP or ring backs are moved to the next day. The practice said this increased GP availability at periods of high demand and it also maintained a balanced workload for GPs. The practice had expanded the role of the practice nurse team (and provided additional training to do so) to enable them to deliver triage, minor illness and chronic disease management which allows nurses to focus on other duties, such as long-term conditions and chronic disease management. **The practice had an open-door policy and staff we spoke to confirmed this. ***Staff had not received equality and diversity training in the last year. The practice manager confirmed this would be scheduled. 	

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

Source	Feedback
Staff feedback	Staff said they were happy working at the practice and management were approachable.

Governance arrangements

There were no 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.	N*
Staff were clear about their roles and responsibilities.	N**
There were appropriate governance arrangements with third parties.	Y

Explanation of any answers and additional evidence:

- Policies and procedures were available in reception, in the practice managers office and electronically. However, some staff were vague of how to access the practices policies and procedures. The practice manager confirmed after the inspection, access to policies and procedures was included in staff induction, staff sign to confirm they have read and understood them. Any changes to policies were circulated via email to staff and discussed at staff meetings.'
- *There was a basic system in place to monitor staff training, all training certificates were kept in individual staff files which were reviewed by the practice manager. The practice manager also used quarterly practice in-house training sessions as a prompt to review staff training needs. The practice manager said they would strengthen the system by implementing a training matrix.
- On the day of inspection staff could not locate some records. These included; risk assessments for liquid nitrogen and Infection prevention and control (IPC) audits. The practice submitted these following the inspection.
- Four Patient Group Directives had not been reviewed.
- The practice had weekly partnership meetings (which included practice nurses when appropriate). We saw evidence that all aspects of practice management, QOF, NICE guidance, clinical audits, significant events and complaints were discussed.
- The practice held four practice meetings a year with all practice staff. These were predominantly training sessions, but significant events and practice management issues were also discussed.
- The practice had monthly nurse meetings with the practice manager and monthly non-clinical meetings to discuss service provision and training. However, some non-clinical staff said they didn't always feel involved in the meetings, they were ad-hoc and they got on with their jobs.
- **Staff were not always clear on their roles and responsibilities, for example a member of the non-clinical team had recently acted as a chaperone and they had not received chaperone training. Staff were not always clear on what to do in the event of a medical emergency or how to ensure business continuity.

Managing risks, issues and performance

The practice did not always 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.	N*
There were processes to manage performance.	P**
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	P***
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	P****
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Explanation of any answers and additional evidence:

- *The practice had some assurance systems. For example, there was a basic system to monitor staff training.
- Three clinical staff said they received annual appraisals. One out of two non-clinical staff we spoke with said they had not received an appraisal. We viewed two staff files and there was no record of appraisals in 2019. All staff we spoke to said they felt supported. The practice manager

confirmed all appraisals were due in February 2020

- The practice used Doncaster CCGs primary care matrix to monitor quality. The matrix identified they had scored low on online access and they now offer more triage.
- **An emergency medicines risk assessment had not been completed to assess which emergency medicines to stock. Required improvements had been identified in the IPC audit for example, there were no hands-free operated taps in the toilets. However, there was no action plan in place on the day of inspection to address this. After the inspection the practice confirmed the action plan had been updated.
- ***The practice had a business continuity plan in reception and in the practice managers office. However, some staff were not aware of the business continuity plan and where the emergency medicines were kept.

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	P*
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • **An emergency medicines risk assessment had not been completed to assess which emergency medicines to stock. 	

If the practice offered online services:

	Y/N/Partial
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
Any unusual access was identified and followed up.	NA

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

Feedback from Patient Participation Group.

Feedback	
<ul style="list-style-type: none"> The PPG met quarterly. They said they felt involved in the running of the practice and appropriately informed of any practice management issues. 	

Any additional evidence	
<ul style="list-style-type: none"> The practice said they used the PPG as a forum to contribute ideas to improve and develop the practice. They said all suggestions and concerns from the PPG were encouraged. 	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had trained healthcare assistants and expanded their roles to complete additional duties, for example, immunisations, basic wound care, aural hygiene and assisted GPs with minor surgical procedures. The practice trained medical and nursing students. One of the practice nurses had received an award for 'commitment to general practice'. 	

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

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

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

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

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

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

Glossary of terms used in the data.

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