

Care Quality Commission

Inspection Evidence Table

Parkwood Family Practice

(1-549710774)

Inspection Date: 19 May 2023

Date of data download: 02/05/2023

Overall rating: Requires Improvement

We carried out an announced inspection at Parkwood Family Practice on 10 November 2022. Overall, the practice was rated as Requires Improvement. We rated the practice as Inadequate for providing safe services, Requires Improvement for providing effective and well- led services and Good for providing responsive services. We issued both a Warning Notice and a Requirement Notice as part of our enforcement action.

We found:

- Patients' needs were assessed, but care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance.
- Patients with long-term conditions were not always receiving relevant reviews that included all elements necessary in line with current best practice guidance.
- Recruitment checks were not always carried out in accordance with regulations and practice policy.
- Staff vaccination was not always maintained in line with current UK Health and Security Agency guidance.
- Risks to patients, staff and visitors were not always assessed, monitored or managed effectively.
- Systems and processes for managing and responding to significant events were not effective.
- Staff induction training was not being formally recorded and the provider was unable to demonstrate that all clinical staff had received training in recognising and managing sepsis.
- Leaders were not aware of all required improvements to ensure the quality, safety and performance of the service.
- Improvements were required to the processes and systems that supported good governance and management.
- The practice's processes for managing risks, issues and performance were not always effective.

At this inspection we rated the practice as Requires Improvement overall. We rated the practice as Good for providing well led service. We rated the practice as Requires Improvement for providing safe and effective services because:

- Further improvements were required to ensure an effective and standardised approach was applied to the safe care and treatment of patients prescribed high-risk medicines and those with long-term conditions.
- Recruitment checks and storage of staff files were now carried out in accordance with regulations and practice policy.
- Staff vaccination was now being maintained in line with current UK Health and Security Agency

guidance.

- Risks to patients, staff and visitors were being routinely assessed, monitored and managed effectively.
- Systems and processes for managing and responding to significant events had been improved and embedded effectively.
- Staff induction training was being formally recorded and the provider was able to demonstrate that all clinical staff had received training in recognising and managing sepsis.
- Leaders were aware of all required improvements to ensure the quality, safety and performance of the service.
- Improvements had been made to the processes and systems that supported good governance and management. However, further improvements were required.
- The practice's processes for managing risks, issues and performance had been improved and were now always effective.

Safe

Rating: Requires Improvement

At our previous inspection in November 2022, we rated the practice as Inadequate for providing Safe services because:

- Recruitment checks were not always carried out in accordance with regulations and practice policy.
- Staff vaccination was not always maintained in line with current UK Health and Security Agency guidance.
- Risks to patients, staff and visitors were not always assessed, monitored or managed effectively.
- Systems and processes for managing and responding to significant events were not effective.

At this inspection, we rated the practice as Requires Improvement for providing Safe services because:

- Recruitment checks and storage of staff files had been improved and were carried out in accordance with regulations and practice policy.
- Staff vaccination was now being maintained in line with current UK Health and Security Agency guidance.
- Risks to patients, staff and visitors were being routinely assessed, monitored and managed effectively.
- Systems and processes for managing and responding to significant events had been improved and embedded effectively.

However,

- Further improvements were required to ensure an effective and standardised approach was applied to the safe care and treatment of patients prescribed high-risk medicines and those with long-term conditions.

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>The provider had a designated safeguarding lead. All staff knew how to identify and report concerns. There were policies which were accessible to all staff. The policies outlined who to contact for further guidance if staff had concerns about a patient's welfare.</p> <p>The practice had a Disclosure and Barring Service check policy and procedure (DBS – a check which enables employers to check the criminal records of current and potential employees to ascertain whether they are suitable to work). We looked at the records of staff employed and found all staff had the most appropriate check undertaken.</p> <p>The practice had a clear policy in use for staff who acted as chaperones. We saw there were notices in the practice that advised patients chaperones were available if required. All staff who acted as chaperones were trained for the role.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice maintained records of up to date information relating to staff indemnity insurance and proof of registration with professional bodies. For example, the General Medical Council and the Nursing and Midwifery Council.</p> <p>At our inspection in November 2023, we viewed 5 staff files and found they did not include information required. For example, references, health check questionnaires and proof of staff vaccinations (rubella, tetanus, MMR and Covid). Following the inspection, the provider wrote to us to show the issues identified with staff recruitment files had been rectified. However, there was no evidence that action had been taken regarding staff's vaccination status.</p> <p>During this inspection, we viewed 3 staff files and found they included information required. For example, references, health check questionnaires and proof of staff vaccinations (rubella, tetanus, MMR and Covid). Files had also been individualised and were stored appropriately.</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: 14/09/2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: 18/10/2022	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in November 2022, the provider was unable to demonstrate they had a fire risk assessment. We requested copies of fire drill records to be sent to us following the inspection, as they could not be located at the time. The provider sent us a fire drill record which was dated the day after the inspection and confirmed that although weekly fire drills were conducted, they had not been formally recorded.</p> <p>Legionella (a bacterium found in water supplies which can cause severe respiratory illness) testing and routine systems and processes for monitoring of this were being maintained. However, testing of water temperatures and flushing of little used pipes were not being monitored and recorded.</p> <p>Records showed that portable appliance testing (PAT) had not been carried out within the last 12 months. The last PAT was dated July 2020. The provider sent us information following the inspection, to show that calibration tests of equipment had been completed in December 2021 and were scheduled for annual testing on 23 December 2022. However, no evidence of PAT dates or regular visual inspection of electrical equipment was provided.</p> <p>During this inspection we found:</p> <ul style="list-style-type: none"> • A fire risk assessment had been completed and no issues had been identified. • A fire drill had been recorded as having been completed on 30 November 2022, further drills had been recorded for April 2023 and the next scheduled for November 2023. • Weekly fire alarm testing had been established and recorded consistently. • Legionella testing and monitoring had been completed in December 2022. There was a test certificate to confirm this. Monthly testing of water temperatures and flushing of little used pipes were being routinely monitored and recorded. • PAT had been carried out on 29 November 2022. There was a test certificate to confirm this. 	

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: November 2022 and 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: At our last inspection in November 2022, we requested a copy of the most recent infection prevention and control (IPC) audit to be sent to us following the inspection. However, this was not received. Therefore, the provider was unable to demonstrate they had suitably risk assessed and audited the risks associated with IPC.</p> <p>During this inspection, we saw that an IPC audit had been conducted in November 2022 and repeated in April 2023. There was clear recording of the actions taken to address identified issues. For example, specimens received by the practice after the arranged hospital collection has occurred. The practice had worked with primary care network (PCN) practices to arrange an alternative collection time, to ensure specimens were not left at the practice overnight.</p> <p>We observed the premises to be clean and tidy and saw that all relevant staff were adhering to current best practice guidance on COVID-19. The practice had a designated lead for infection prevention and control (IPC), who had the required level of training to undertake this role.</p>	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y
<p>Explanation of any answers and additional evidence: At our previous inspection in November 2022, staff told us they had received an induction when they were employed at the practice. However, in the staff files and training records we viewed, there was no documentary evidence to show that induction training had been formally recorded.</p> <p>From staff training records we saw that one member of the staff team had completed sepsis training. After the inspection, the provider sent us documentary evidence to show that seven staff had received training in suspected sepsis (two clinical staff and five non-clinical staff members).</p> <p>During this inspection, our review of staff files and records showed that all staff had now completed sepsis training. Copies of induction records had also been saved to individual staff files.</p>	

Information to deliver safe care and treatment

Staff did not consistently have 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.	Partial
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in November 2022, we completed a series of searches on the practice's clinical records system. These searches were completed with the consent of the provider, and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance.</p> <p>We reviewed the records of 5 patients who had been prescribed; disease modifying anti-rheumatoid (DMARD) medicines and ACEI/ARB (used for treating patients with high blood pressure, heart problems or kidney disease). We found that not all patients had been appropriately recalled for monitoring, in line with current legislation and best practice guidance.</p> <p>We also identified that 2 out of 5 patients who had received a medicines review, were coded as having the review completed but there were no notes in the patient record to demonstrate the discussion that took place as part of the review.</p> <p>The provider sent us an action plan which told us they had reviewed the records of all the patients on these medicines and had taken relevant action.</p> <p>During this inspection, our clinical searches for patients prescribed DMARDs showed that all patients had been recalled for monitoring, in line with current legislation and best practice guidance. However, we reviewed the records of 5 patients who had been prescribed ACEI/ARB and found that not all patients had been monitored and reviewed in line with current legislation and best practice guidance.</p>	

Appropriate and safe use of medicines

The practice did not have consistent 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) (01/01/2022 to 31/12/2022) (NHSBSA)	1.12	0.88	0.86	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2022 to 31/12/2022) (NHSBSA)	8.2%	8.2%	8.1%	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 (01/07/2022 to 31/12/2022) (NHSBSA)	6.71	5.69	5.24	Tending towards variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	161.9‰	133.0‰	130.3‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	0.05	0.58	0.56	Significant variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	3.4‰	6.8‰	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.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Partial

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.	Partial
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.	N/A
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:</p> <p>At our previous inspection in November 2022, we looked at the equipment for use in an emergency and found that this was routinely checked and monitored. We saw the practice had an Automated External Defibrillator (AED). However, there was only one set of defibrillator pads available, when the requirement is two sets.</p> <p>We completed a series of searches on the practice's clinical records system. These searches were completed with the consent of the provider, and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance.</p> <p>We reviewed the records of 5 patients who had been prescribed angiotensin-converting-enzyme/angiotensin receptor blockers (ACEI/ARB- used for treating patients with high blood pressure, heart problems or kidney disease) and found three of these patients had not been appropriately recalled for their monitoring within the required timescale. During our site visit, the practice management team provided us with an overview of the actions they had taken in relation to the above patients' records, as well as those we didn't view as part of the inspection process (for patients prescribed ACEI/ARB). We saw from the practices' action plan; timescales for actions and completion were recorded as March 2023.</p> <p>During this inspection, we looked at the equipment for use in an emergency and found routine checking and monitoring was being maintained. We saw the practice had two sets of defibrillator pads available.</p> <p>Our clinical searches for patients prescribed disease modifying anti-rheumatic drugs (DMARDs) identified that 4 of the 5 patients had been monitored and reviewed in line with current legislation and best practice guidance. The search also showed that 3 out of 8 patients prescribed azathioprine (used to suppress cells in the body that cause inflammation) were potentially overdue, however it was identified that only 1 patient was overdue for monitoring, and we saw that reminders had been sent.</p>	

For patients prescribed ACEI/ARB, we found that all 5 patients were overdue an annual blood test. We saw that all these patients had been sent reminders. However, these had not been followed up, where patients had failed to attend or book appointments, meaning that monitoring had not occurred within the required 12 months.

At the time of our site visit, the provider told us about the actions being taken to ensure these patients were recalled for monitoring purposes. For example, all patients that had previously received 2 reminders had been contacted by telephone to arrange an appointment.

The provider told us the implementation of a tracker spreadsheet, would also be utilised for patients requiring monitoring tests, as well as scheduling dates for letter reminders to be sent with advice about short scripting if they did not attend.

Following our inspection, the provider wrote to us with documentary evidence to show that:

- The patients (identified by our clinical searches) prescribed ACEI/ARB had received a patient notes review. The analysis of these showed that 2 of these patients had received appropriate blood tests at the time of our searches and 1 patients result had been sourced from the secondary care provider.
- The practice had updated their DMARDs and high-risk medicines policy, which referred to the recall and short scripting processes for staff to follow. The document included provisions for medicines which could not be short scripted for patient safety reasons. We saw from an updated copy of tracker spreadsheet, that all patients that had previously received 2 reminders had been contacted by telephone to arrange an appointment, as well as dates scheduled for letter reminders to be sent with advice about short scripting if they did not attend. However, these newly implemented systems required time to be embedded effectively.

The provider told us that 97% of the 440 patients that are on the ACEI/ ARB had received a blood test in the last 12 months. However, there was no documentary evidence provided to show this.

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:	7
Number of events that required action:	4
Explanation of any answers and additional evidence: At our previous inspection in November 2022, we found the practice had a policy which governed significant event reporting. We saw the policy included how staff should report to the practice manager when they were completing a form in relation to a significant event occurrence. We looked at the two completed forms and	

found that one was completed appropriately and the other was not. Both forms had been completed by the practice manager supporter (deputy) and not the staff involved. We also saw the partially completed form did not include any details of the date, time or people involved in the incident. It had also not been signed as completed. The form detailed actions taken after the incident had occurred to prevent them reoccurring. Following our inspection, the provider sent us documentary evidence of three further significant events that had occurred between February 2022 and the date of the inspection. We saw that sections for what could have been done differently and what has been learned were left blank. Minutes of meetings provided before the inspection, did not reflect these events having been discussed with staff.

During this inspection, we found that the system and process for significant event reporting had been improved and embedded effectively. We saw that these were managed in line with the practices own policies and procedures, discussed at meetings and learning shared. Where our clinical searches had identified an issue with the wrong letter being sent to patients, in relation to the risks of taking a specific medicine, the practice had commenced a significant event investigation, to determine if the incident was isolated to the practice or an issue for all practices within the Medway Rainham PCN.

Following our inspection, the provider wrote to us to show their significant event investigation, regarding the issue with the wrong letter being sent to patients, had been concluded. It was found to be an incident isolated to the practice but had been shared with the PCN for learning purposes.

Example of significant events recorded and actions by the practice.

Event	Specific action taken
Rising temperature of a vaccine storage refrigerator	<p>The practice had identified that the fridge temperature was rising to outside of the accepted range of 2-8 degrees centigrade. As part of their investigation, they removed all vaccines and stored them in a refrigerator that was working effectively. They reported the incident to the fridge and vaccine manufacturers.</p> <p>The investigation showed that the practice's cold-chain policy was effective in identifying and reporting issues.</p>

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence: At our last inspection in November 2022, we saw examples of actions taken on recent alerts. For example, regarding sodium valproate. The provider was able to demonstrate that all relevant safety alerts had been responded to. However, we reviewed the records of five patients and found one patient remained on a combination of medicines that increased their risk of heart problems, without anything in their records to indicate the risk had been discussed with the patient. During our site visit the practice management team provided us with an overview of the actions they had taken in relation to the above patient. We saw that the patient had been contacted and the necessary changes had been made.</p>	

During this inspection, our clinical searches identified the provider was able to demonstrate that all relevant safety alerts had been responded to. We reviewed the records of 5 patients and found all patients had received a letter regarding the risks associated with prescribed Sodium-glucose co-transporter-2 (SGLT2) inhibitors (prescribed to lower blood sugar levels) following a recent alert. However, the letter had been titled correctly but the content did not reflect the correct information and detailed another medicine. The practice told us these letters had been sent by a pharmacy technician (who worked independently with the practice).

At the time of our site visit, the practice had commenced a significant event investigation, which would ensure that a system wide procedure would be implemented (either at the practice or within all the PCN practices) to ensure there was routine checking of letters sent on behalf of the practice.

Effective

Rating: Requires Improvement

At our last inspection in November 2022, we rated the practice as Requires Improvement for providing Effective services because:

- Patients' needs were assessed, but care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- Patients with long-term conditions were not always receiving relevant reviews that included all elements necessary in line with current best practice guidance.
- Staff induction training was not being formally recorded and the provider was unable to demonstrate that all clinical staff had received training in recognising and managing sepsis.

At this inspection, we rated the practice as Requires Improvement for providing Effective services because:

- Patients' needs were assessed, but further improvements were required for the care and treatment for some patients on high-risk medicines and those with long term conditions.
-

Staff induction training was being formally recorded and the provider was able to demonstrate that all clinical staff had received training in recognising and managing sepsis.

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 but further improvements were required for the care and treatment of some patients on high-risk medicines and those 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.	Partial
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:

At our last inspection in November 2022, we completed a series of searches on the practice's clinical records system. These searches were completed with consent and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance.

We looked at the records of 5 patients who had a potential missed diagnosis of diabetes. We found that none of these patients had been added to the practice's diabetic register. We also saw that 2 patients had been started on medicines but there was no evidence they had been referred for diabetic screening or diabetic retinopathy. During our site visit, the practice management team provided us with an overview of the actions they had taken in relation to the above patients' records, as well as those we didn't view as part of the inspection process (for patients with a potential missed diagnosis of diabetes). We saw from the practice's action plan; timescales for actions and completion were recorded as January 2023.

During this inspection, we looked at 5 patients records each for: patients with a potential missed diagnosis of diabetes; patients prescribed 2 or more courses of rescue steroids; patients with chronic kidney disease (CKD) Stages 4 or 5 who have not had blood test monitoring in the last 9 months and patients with hypothyroidism who have not had thyroid function test monitoring for 12 months.

Our clinical searches identified that all patients with a potential missed diagnosis of diabetes had been seen, referred and appropriately added to the register. However,

- 4 patients prescribed 2 or more courses of rescue steroids had not received any follow up to ensure the treatment had been effective and there were no side effects experienced by the patient.
- 2 patients with CKD stages 4 or 5 had not had blood test monitoring in the last 9 months. However, they had been recalled twice.
- 4 patients with hypothyroidism had not had thyroid function test monitoring for 12 months. However, they had been recalled twice.

We identified that recalls were being sent to patients after they were overdue for monitoring, which resulted in further delays to the required timescales. We discussed this with the provider at the time of the inspection and were told the implementation of the tracker system would help identify these patients sooner, allowing for letters and reminders to be sent in advance of the timescale of monitoring.

After the inspection the provider sent us documentary evidence to show that all these patients had been contacted by telephone to book an appointment and their details had been entered onto the tracker spreadsheet. There was also an action plan to ensure new systems and processes for recall could be monitored more effectively and to avoid unnecessary delays.

Following our inspection, the provider wrote to us with documentary evidence to show that:

- All patients who are prescribed Rescue packs have been read coded as "Prescription of respiratory disease rescue medication". The practice had a plan to book a follow up appointment at the time of prescribing for the following week. The prescribing of rescue pack medicines had also discussed at a practice meeting and raised as a significant event to ensure learning.
- The patients (identified by our clinical searches) with CKD stages 4 or 5 had received a patient notes review. The analysis of these showed that both of these patients had received appropriate blood tests at the time of our searches.

The provider told us that 99% of the 231 with hypothyroidism, had received a blood test within the last 12 months. They stated that all patients identified in our clinical searches had a blood test requested around the time they were due and were aiming to monitor this continually. However, there was no documentary evidence provided to show this.

Effective care for the practice population

Findings

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

Management of people with long term conditions

Findings

- Patients with long-term conditions were not consistently being offered an effective 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 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.
- Young people were able to access sexual health services and contraception. There were posters in the waiting room which included information about the local genitourinary medicine (GUM) clinic, opening times and how to self-refer. There was also information on how to access chlamydia screening.

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 influenzae 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)	28	30	93.3%	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)	31	31	100.0%	Met 95% WHO based target
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)	31	31	100.0%	Met 95% WHO based target
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)	31	31	100.0%	Met 95% WHO based target

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)	37	38	97.4%	Met 95% WHO based target
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Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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)	73%	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)	77.5%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (9/30/2022 to 9/30/2022) (UKHSA)	74.0%	N/A	80.0%	Below 80% target
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)	73.1%	57.4%	54.9%	No statistical variation

Any additional evidence or comments
The practice provided us with unverified data relating to cervical screening of persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64. The data showed the practice had achieved 83% for the uptake rate.

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 2 years: Records showed that 3 clinical audits had been carried out in the last 2 years. The practice had completed an	

audit between November 2022 to February 2023 in relation to opioids (medicines usually prescribed to block moderate to severe pain and are a sedative) being prescribed for patients with a fear of flying. The audit identified the number of patients prescribed these medicines for this purpose. The practice checked National Institute for Clinical Excellence (NICE guidance) as part of the audit, which states that these medicines are not recommended to prescribe for this purpose. As a result, the practice created an information leaflet to give to patients who request these medicines for fear of flying and were then written to with further information.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in November 2022, staff told us they had received induction training. However, we looked at staff personnel and training records and found that staff induction training was not always formally recorded.</p> <p>Staff training files reviewed, identified that not all staff had received training in sepsis. The provider wrote to us following the inspection and provided evidence to show this had been completed by 7 staff following the inspection (5 non-clinical and 2 clinical).</p> <p>During this inspection, staff training files reviewed identified that all staff had received training in sepsis. We saw from staff personnel and training records that staff induction training had been formally documented and stored within their individual files.</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
<p>Explanation of any answers and additional evidence: We saw that information was available for patients in the waiting room and on the practice website. For example, local campaigns for health advice, fitness and dietary programmes; as well as external bodies who provided support services.</p>	

Helping patients to live healthier lives

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

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

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y

Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence: We looked at the records of 2 patients with DNACPR decisions. We found there were clearly documented reasons for the DNACPR decisions that were not discriminatory or based on assumptions about the person's quality of life, and there was a record of a discussion with the person (and their representative, where appropriate).</p>	

Well-led

Rating: Good

At our last inspection in November 2022, we rated the practice as Requires Improvement for providing well-led services because:

- There was compassionate leadership at all levels. However, leaders were not aware of all required improvements to ensure the quality, safety and performance of the service.
- Improvements were required to the processes and systems that supported good governance and management.
- The practice's processes for managing risks, issues and performance were not always effective.
- Improvements to care and treatment were required for some types of patient reviews as well as subsequent follow-up activities.

At this inspection, we rated the practice as Requires Improvement for providing Well-led services because:

- There was compassionate leadership at all levels and leaders were aware of required improvements to ensure the quality, safety and performance of the service.
- Improvements had been made to ensure the processes and systems that supported good governance and management were embedded effectively.
- The practice's processes for managing risks, issues and performance were now effective.

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.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<p>Explanation of any answers and additional evidence: At our last inspection in November 2022, we found that there was a lack of awareness by leaders that improvements to quality, safety and performance were required in relation to the following:</p> <ul style="list-style-type: none"> • Staff vaccination, training, induction and recruitment procedures. • Significant event management and processes. • Risk management, in particular; fire safety, health and safety, legionella, infection prevention and control. • Reviews of patients with long-term conditions. • Patients' care and treatment not always being delivered in line with current legislation, standards and evidence-based guidance. • Staff induction training not being formally recorded and all clinical staff having not received training in recognising and managing sepsis. • Improvements required to the processes and systems that supported good governance and management. <p>During this inspection, we found the awareness by leaders that improvements to quality, safety and performance had improved. Staff vaccination, training, induction and recruitment procedures; significant event management and processes; risk management (in particular; fire safety, health and safety, legionella, infection prevention and control); staff induction training being formally recorded; all clinical staff having received training in recognising and managing sepsis and improvements required to the processes and systems that supported good governance and management had all been improved and embedded effectively.</p> <p>However, further improvements were required in respect of some:</p> <ul style="list-style-type: none"> • Reviews of patients with long-term conditions. • Patients' care and treatment not always being delivered in line with current legislation, standards and evidence-based guidance. <p>As actions taken by the provider to address these had not resulted in a standardised approach, the provider sent us documentary evidence following the inspection to show how this would be addressed and the actions to be taken, to ensure there was a standard approach to all patient with long term conditions and those prescribed high-risk medicines.</p>	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y

Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: Staff we spoke with were aware of the practices' vision, values and strategy. They understood their role in supporting the development and achievement of these.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: At our last inspection in November 2022, systems and processes for managing and responding to significant events were not effective. We did not see any records to show that when people were affected by things that went wrong, they were given an apology and informed of any resulting action. During this inspection, systems and processes for managing and responding to significant events had been improved and were effective. We saw records to show that when people were affected by things that went wrong, they were given an apology and informed of any resulting action.	

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
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
<p>Explanation of any answers and additional evidence: At our previous inspection in November 2022, there were policies available on the practice intranet, many of which were dated 31 October 2022. There was no information available to show whether these had been reviewed or if they were new policies.</p> <p>We saw that governance structures and systems were not always effective, as they had not identified risks associated with:</p> <ul style="list-style-type: none"> • Staff vaccination records not being up to date and in line with current best practice guidance. • Staff recruitment procedures not being in with regulatory requirements. • Staff having not received training in the recognition and management of sepsis. • Significant event management and processes not being conducted in line with the practice own policy. • The absence of; fire safety, health and safety, legionella, infection prevention and control risk assessments and audits. • The continued review of patients with long-term conditions, in line with current best practice guidance. <p>During this inspection, we found the practice had purchased a software system for the purpose of tracking when policies and procedures had been updated and/or reviewed. All staff had access to this system. We saw that governance structures and systems had been improved. However, these processes needed further improvements in relation to the continued review of patients with long-term conditions, in line with current best practice guidance. The provider had a clear action plan to address this, which was discussed at the time of the site visit and confirmed by documentary evidence sent to us following the inspection.</p>	

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance. However, further improvements were required.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence: At our previous inspection in November 2022, the provider was unable to demonstrate their processes and systems were effective in the management of risks from:</p> <ul style="list-style-type: none"> • Employing staff without carrying out recruitment checks in accordance with regulations. • Not maintaining staff vaccination in line with current UK Health and Security Agency guidance. • The absence of the management of some environmental risk assessments such as fire, health and safety, legionella and IPC. • Managing and responding to significant events. 	

- Clinical staff having not received training in recognising and managing sepsis.

From our clinical searches, we saw that reviews and monitoring of patients were not always completed in line with best practice guidance. We raised this with the provider and were shown an action plan that had been implemented to ensure all reviews would be managed effectively. However, this did not include who would complete these or how the actions would be undertaken.

During this inspection, we found that risk management systems and processes had been improved and were effective for staff recruitment, training, premise checks and significant event management. However, further improvements were required for the reviews and monitoring of patients, to ensure there was a standardised approach.

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
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in November 2022, we saw from records viewed that meetings were held, and minutes were being maintained, stored, and accessible. Minutes showed that learning and actions from complaints and investigation outcomes were recorded. However, significant events were shown as nil received this quarter, when the provider had retrospectively sent us copies of incidents that had occurred during these timescales.</p> <p>During this inspection, records of meeting showed that significant events had been added as an agenda item, were discussed and learning shared where appropriate.</p>	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	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

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence: At our previous inspection in November 2022, learning from complaints and safeguarding investigations were shared. However, significant event reporting was not effective to ensure learning was shared and used to make improvements.</p> <p>During this inspection, we found significant event reporting was now effective, to ensure learning was shared and used to make improvements.</p>	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.

- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

Glossary of terms used in the data.

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

