

# Care Quality Commission

## Inspection Evidence Table

### Braithwell Road Surgery (1-3910418013)

Inspection date: 7 and 12 July 2022

Date of data download: 06 July 2022

## Overall rating: Good

We inspected the practice on 17 December 2018 when we rated the practice as requires improvement overall and for providing safe, effective and well led services and all population groups as requires improvement.

We followed up with an inspection in August 2019 when we found most areas requiring improvement had been addressed and the practice was rated as good for effective services. However, the practice remained rated as requires improvement overall and for providing safe and well led services because we were not assured all safety alerts had been received or actioned and the provider's involvement in monitoring the service had been minimal.

When we inspected the practice on 29 and 30 September 2021, we found the practice had met the breach of regulations relating to safety alerts and had addressed most of the recommendations from the previous inspection. The practice was rated as good overall and for providing effective and well led services. However, they remained rated as requires improvement for providing safe services because we found additional concerns relating to recruitment, staff immunisation status, staff training, management of patients prescribed high risk medicines, emergency medicines and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms.

When we inspected the practice on 7 and 12 July 2022, we found the areas of concern had mostly been addressed and systems had improved. The practice is now rated as good overall for providing safe, effective and well led services. The practice had maintained their focus on provision of patient centered care throughout the pandemic and there were high levels of patient satisfaction with all aspects of the care and ease of access. The practice patient population had recently expanded by 300 due to the closure of a nearby practice and they had been working to update their records and ensure these new patients were reviewed where necessary.

## Safe

## Rating: Good

At the inspection in August 2019 we rated the practice as **requires improvement** for providing safe services because we were not assured all safety alerts had been received or actioned.

At the inspection in September 2021 we rated the practice as **requires improvement** for providing safe services because whilst we saw improvement in the management of safety alerts additional concerns

were found relating to recruitment, staff immunisation status, staff training, management of patients prescribed high risk medicines and emergency medicines.

At the inspection in July 2022 we rated the practice as **Good** as we found the areas of concern had mostly been addressed and systems had improved.

### 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           |
| Explanation of any answers and additional evidence:  |             |
| At the inspection in September 2021 all but two members of staff had completed Adult or Child safeguarding training in the last 12 months.   |             |
| At the July 2022 inspection the training matrix showed clinical staff had completed level three and the all non-clinical staff had now completed level one and two.  |             |

| 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.   | P           |
| Explanation of any answers and additional evidence:   |             |
| At the 2018 inspection we found:  |             |
| <ul style="list-style-type: none"> <li>Health assessments were not completed.</li> </ul>  |             |
| At the inspection in 2021 we found:   |             |
| <ul style="list-style-type: none"> <li>Health declarations were in place. However we also found references had not been obtained for one non-clinical member of staff and information on staff vaccination status not been obtained in line with the Department of Health Immunisation against infectious disease guidance (the Green Book).</li> </ul> |             |

At the July 2022 inspection we found

- Vaccination records had been requested from the staff and had mostly been received.
- We looked at two recruitment records and found recruitment checks had been completed. Where one member of clinical staff had to be employed temporarily to cover staff sickness an initial verbal reference had been taken and written references had been requested. Other checks such as professional registration, training and disclosure and barring service (DBS) checks had been completed before employment had commenced.

| Safety systems and records  | Y/N/Partial |
|---|-------------|
| Health and safety risk assessments had been carried out and appropriate actions taken.<br>Date of last assessment: April 2021   | Y           |
| There was a fire procedure.<br>Date of fire risk assessment: February 2021  | Y           |
| Actions from fire risk assessment were identified and completed.  | Y           |
| Explanation of any answers and additional evidence:<br>At the inspection in September 2021 we found: <ul style="list-style-type: none"> <li>• Not all staff had completed the required fire training in the last 12 months due to staff availability and plans were in place to ensure this would be addressed.</li> </ul> At the inspection in July 2022 we found: <ul style="list-style-type: none"> <li>• Most staff, 80%, had completed the fire training in the last 12 months and a training session was scheduled for 14 July 2022.</li> <li>• A meeting had been held on 23 June 2022 with the maintenance manager of building and a review of the risk assessments was pending.</li> </ul> |             |

## 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.<br>Date of last infection prevention and control audit: April 2022  | 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           |
| Explanation of any answers and additional evidence:<br>At the September 2021 inspection we found: <ul style="list-style-type: none"> <li>• The infection prevention and control (IPC) eLearning refresher training had been completed by most staff in the last 12 months.</li> </ul> At the July 2022 inspection we found: <ul style="list-style-type: none"> <li>• The IPC audit had been completed by the advanced nurse practitioner and no issues had</li> </ul> |             |

been identified.

- The IPC training had been completed by 80% of staff in the last 12 months.

### Risks to patients

**There were adequate 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           |

Explanation of any answers and additional evidence:

- The practice nurse hours had recently been increased to enable them to concentrate solely on case management for complex care patients one day per week.
- Clinical staffing had been impacted due to individual circumstances. A locum member of staff had been employed to cover one role and a member of the reception team with the appropriate training had covered another role. A new member of reception staff had also been employed to support the team.
- Sepsis awareness eLearning training had been made available to all staff and most staff had completed this in the last 12 months. Posters relating to signs and symptoms of sepsis were displayed in the practice and systems were in place to escalate any concerns about patients contacting the practice. Requests for appointments were triaged by the clinical staff.

## Information to deliver safe care and treatment

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

|   | Y/N/Partial |
|---|-------------|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.   | Y           |
| There was a system for processing information relating to new patients including the summarising of new patient notes.  | Y           |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.   | Y           |
| Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.   | Y           |
| There was a documented approach to the management of test results, and this was managed in a timely manner.   | Y           |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.  | Y           |
| Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Systems were in place for urgent referrals to be processed the same day and for these to be monitored to ensure patients had been seen.</li> </ul> |             |

## Appropriate and safe use of medicines

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

| Indicator   | Practice | CCG average | England average | England comparison       |
|---|----------|-------------|-----------------|--------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) <small>(NHS Business Service Authority - NHSBSA)</small>                               | 0.99     | 0.87        | 0.79            | No statistical variation |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) <small>(NHSBSA)</small> | 6.8%     | 6.4%        | 8.8%            | No statistical variation |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets   | 5.94     | 5.54        | 5.29            | No statistical variation |

| Indicator  | Practice | CCG average | England average | England comparison                   |
|--|----------|-------------|-----------------|--------------------------------------|
| prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022)<br>(NHSBSA)  |          |             |                 |                                      |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)  | 134.0‰   | 148.5‰      | 128.2‰          | No statistical variation             |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA) | 0.87     | 0.61        | 0.60            | No statistical variation             |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)   | 3.2‰     | 5.7‰        | 6.8‰            | Tending towards variation (positive) |

Note: ‰ means *per 1,000* and it is **not** a percentage.

### Any additional evidence or comments

Above average prescribing of hypnotics and prescribing relating to urinary tract infections had been highlighted at previous inspections.

At the July 2022 inspection we found improvements had been made in all the areas of prescribing related to the above data since the last inspection.

| Medicines management  | Y/N/Partial |
|---|-------------|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff.  | Y           |
| Blank prescriptions were kept securely, and their use monitored in line with national guidance.   | Y           |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).   | Y           |
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.  | Y           |
| There was a process for the safe handling of requests for repeat medicines and evidence of 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. | P (1)       |
| 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   | Y           |

| Medicines management  | Y/N/Partial |
|---|-------------|
| England and Improvement Area Team Controlled Drugs Accountable Officer.   |             |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.  | NA          |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.   | Y           |
| For remote or online prescribing there were effective protocols for verifying patient identity.   | Y           |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.   | Y           |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.  | Y           |
| Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.   | Y           |
| <p>Explanation of any answers and additional evidence:</p> <p>At the inspection in September 2021 we found not all the recommended emergency medicines were provided and a risk assessment had not been undertaken to direct the emergency medicines provision. Whilst we found most patients received appropriate reviews for their condition and/or medication, we found some examples where a review had not been completed within the recommended timeframe or that not all the required monitoring checks had been completed or recorded.</p> <p>At the July 2022 inspection we found:</p> <ul style="list-style-type: none"> <li>• A risk assessment of the emergency medicines provision had been completed and recommended medicines were provided. A new emergency medicines trolley had been purchased and was well organised.</li> <li>• (1) We completed clinical record searches remotely as part of our inspection and found patients prescribed high risk medicines were generally well managed and monitoring was completed. We found the following two areas which required review by the provider:</li> </ul> <p>We reviewed data for high risk medicines used to treat auto-immune conditions – 20 patients were prescribed one of this type of medicine and all had had monitoring checks completed. However, one person had not had one of the required blood tests as part of their review.</p> <p>We reviewed data for medicines used to treat raised blood pressure and heart failure and found 31 patients were prescribed one type of this medication and 10 had not had the required monitoring in the previous six months. The provider advised us they had followed the directions for frequency of tests from secondary care clinicians who prescribed the medicines but would implement six-monthly testing in future. Immediate action was taken by the provider and we were advised arrangements had been made for searches of patients on these medicines to be undertaken and for the community team to undertake visits to housebound patients to complete the required blood tests where required.</p> |             |

**Medicines management****Y/N/Partial**

- The practice had the support of a Primary Care Network (PCN) funded pharmacist two days per week and pharmacy technician once a week. The practice also worked closely with the local Integrated Care Systems (ICS) pharmacist.
- We were told 99% of the patients were now on the electronic prescription service which has enabled the practice to track prescriptions sent to the pharmacy more effectively.



## 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:   | 1           |
| Number of events that required action:   | 1           |
| Explanation of any answers and additional evidence:<br>Staff were aware of the incident reporting systems in place and when to report. |             |

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

| Event  | Specific action taken  |
|--|--|
| Safety concern when all staff but the clinician left the building during the last patient consultation of the day. | Appointment system reviewed and safety systems put in place to minimise the risk of the incident reoccurring. All staff advised of new processes and reasons for this. |

| 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:<br>At the September 2021 inspection we found: <ul style="list-style-type: none"> <li>A log of safety alerts received was maintained and this included the action taken in response. However, it was not always clear from the records who had taken the required action.</li> </ul> At the July 2022 inspection we found: <ul style="list-style-type: none"> <li>Records had been improved to show who had acted in response to safety alerts.</li> <li>We completed clinical records searches of medicines identified in safety alerts. We reviewed patients prescribed a medicine which may present a risk to women of child bearing age. We found eight patients prescribed this type of medicine and reviewed five of these patient records. We found no evidence in four records that advice had been given relating to the risks and one of these patients was not taking any contraception to minimise related risks. The provider said they would review these patients.</li> </ul> |             |

## Effective

## Rating: Good

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

### Effective needs assessment, care and treatment

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

|  | Y/N/Partial |
|--|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice.   | Y           |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.   | Y           |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.   | Y           |
| We saw no evidence of discrimination when staff made care and treatment decisions.   | Y           |
| Patients' treatment was regularly reviewed and updated.  | Y           |
| There were appropriate referral pathways to make sure that patients' needs were addressed.   | Y           |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated.   | Y           |
| The practice had prioritised care for their most clinically vulnerable patients during the pandemic  | Y           |
| Explanation of any answers and additional evidence:  |             |
| <ul style="list-style-type: none"><li>• The practice used local and national guidelines such as the South Yorkshire and Bassetlaw Integrated Care System (ICS) guidelines and National Institute for Health and Care Excellence (NICE) guidance and they were able to access these electronically. Staff also used assessment and care templates within the electronic patient record system to ensure consistency and implementation of up to date guidance.</li><li>• All requests for appointments were triaged by clinical staff and systems were in place to escalate any concerns about patients contacting the practice. Urgent appointment requests were reviewed by GPs. Systems were in place to manage and monitor urgent referrals</li><li>• The practice had continued to provide an effective patient focused service during the pandemic and recent staff absences.</li></ul> |             |

## 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.
- 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.

At the September 2021 inspection all patients with a learning disability were offered an annual health check. There was some improvement in the number of care plan reviews completed for patients with a Learning Disability. They told us 10 of the 24 patients on their register had been seen although patients had not wanted to attend during the pandemic.

At the July 2022 inspection we found the practice had had held additional clinics in March 2022 to enable them to offer reviews to patients. 20 of 28 patients had received their annual review. Of the eight who had not been reviewed, five were new patients and three had not responded to invites and had been referred to the local learning disability team for review.

- 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 assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. These patients have been offered telephone or face to face appointments depending on the patient's needs. The practice now had a community psychiatric nurse (CPN), employed by the local primary care network (PCN), who held a weekly clinic at the surgery to support patients with depression.
- Of the 17 patients with dementia on the practice register four had had reviews since April 2022 and additional clinics were due to be arranged to encourage attendance.

## Management of people with long term conditions

### Findings

As part of our inspection, we conducted a series of additional searches on patient records to review the practice's procedures for the management of patients with long term conditions. We found patients with long-term conditions were mostly offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. We identified some areas which required review for example:

- One search reviewed the monitoring of patients with chronic kidney disease. Our search identified six patients who were coded as having this diagnosis and records showed four of the five patients, we reviewed had not had the monitoring checks in the last 6 months. On review of the records with the provider we found three of these patients were having the checks in secondary care settings, but the practice was unable to download the blood results to the patient record system.

- A second search reviewed the management of patients with asthma who had been prescribed two or more courses of rescue steroids within the last 12 months and we found these patients to be generally well managed. Our search identified 16 patients of 44 on the asthma register, had been prescribed two or more courses of rescue steroids. We undertook a detailed review of five patients' records, which showed all these patients had received an annual asthma review within the last 12 months. The reason for prescribing the rescue medicine and detail of symptoms was recorded and there was evidence of systems to review response to the treatment within a week of an acute exacerbation of asthma. We found three patients on high doses of cortico-steroids inhalers who required a steroid card and one patient where the inhaler dosage prescribed was slightly different to hospital letter request. The provider told us they would review these patients.
- Another search reviewed patients with a potential missed diagnosis of diabetes. Our search identified just one patient was not appropriately coded on their records and the provider confirmed they would review this. Following the inspection the provider told us the patient had been contacted in February 2022 to ask them to attend to discuss their results and further contact was made with the patient after our clinical searches and an appointment had been scheduled for the week of the inspection.
- A further search reviewed the monitoring of patients with a thyroid condition who had not had a thyroid function test in the last 18 months. Our search identified that, of the 130 patients who required monitoring, four patients had not received an appropriate test within this period. We reviewed these patients records and found the practice had been trying to contact them and had sent reminders. One patient had not had the required blood tests completed since 2019. Following the inspection, the provider told us they were addressing this through provision of only weekly prescriptions until a review had been completed.
- A final search reviewed the recording of patients diagnosed with diabetic retinopathy; a complication of diabetes caused by high blood sugar levels. Our search identified that of 276 patients 21 had had high blood sugar levels at the last blood test. We reviewed five patient records and all, but one had had a review following their blood tests and this person's test results were received just prior to our searches.
- During the pandemic patients with chronic obstructive pulmonary disease (COPD) had their reviews completed over the phone due to these patients being at high risk, they were only asked to attend the practice for a blood pressure monitoring check. If the patient wanted to be seen or was experiencing problems, then they were invited in for a face to face appointment. At the time of the inspection 32 of the 123 patients who had COPD had been seen for their annual review since April 2022.
- 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.
- 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.
- Patients with asthma were offered an asthma management plan. During the pandemic asthma reviews were completed over the telephone unless the patient had concerns or wished to be

seen face to face for a review. Since April 2022 all patients had been invited in for a face to face appointment for their annual review. Of the 303 patients with asthma 141 had had reviews since April

- The provider told us they arranged for annual reviews of long-term conditions to be completed as early in the year as possible to enable them to manage winter pressures.

| Child Immunisation   | Numerator | Denominator | Practice % | Comparison to WHO target of 95% |
|--|-----------|-------------|------------|---------------------------------|
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement) | 27        | 27          | 100.0%     | Met 95% WHO based target        |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)  | 35        | 37          | 94.6%      | 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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)  | 35        | 37          | 94.6%      | Met 90% minimum                 |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)   | 35        | 37          | 94.6%      | Met 90% minimum                 |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)  | 46        | 51          | 90.2%      | 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>

### Any additional evidence or comments

At the last inspection we found the practice had improved childhood immunisation rates and had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of five childhood immunisation uptake indicators. Whilst these percentages had dropped slightly the sample size was too small for this to be statistically significant. Where children were not brought for their immunisations the practice referred to the health visitor and the local safeguarding team where appropriate.

| Cancer Indicators  | Practice | CCG average | England average | England comparison       |
|--|----------|-------------|-----------------|--------------------------|
| The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency) | 77.7%    | N/A         | 80% Target      | Below 80% target         |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)   | 77.8%    | 59.0%       | 61.3%           | N/A                      |
| Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)  | 67.0%    | 67.3%       | 66.8%           | N/A                      |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)  | 33.3%    | 49.0%       | 55.4%           | No statistical variation |

#### Any additional evidence or comments

At the July 2022 inspection we found a slight drop in cervical cancer screening uptake which was at 78.8% at the last inspection in September 2021.

The practice nurse had completed training to take samples for cervical screening. Patients who did not attend for cervical screening were followed up.

## Monitoring care and treatment

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

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

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

|  |
|--|
| We reviewed an audit to review compliance with gestational diabetes annual follow up. The purpose of the audit was to identify patients who have had a diagnosis of gestational diabetes and to find out if they had been offered follow up testing as per National Institute for Health and Social Care Excellence (NICE) guidance. A search was undertaken of patients that met the criteria and the results showed that patients had not been effectively reviewed following a post gestational diabetes diagnosis and an ineffective recall system was most likely to be the cause of this. Immediate action was identified to ensure patients had monitoring checks completed and the recall system was improved. Additional measures to monitor compliance with the new action plan were also to be implemented such as an annual audit. |
| Audit of patients prescribed Metformin, a medicine taken for type 2 diabetes, above therapeutic dose. Following an educational session, the provider conducted an audit to check prescribing met clinical guidance which advises the maximum dose of Metformin to be no more than 1g twice daily, to avoid reduced renal function. A search was undertaken, and patients were reviewed where their dose of metformin was above the recommended dose. Reviews of these patients were carried out after three, six and 12 months and changes to treatments or referrals to secondary care were made as required.   |
| An audit of anticoagulation prescribing for patients with prosthetic mechanical heart valves showed no improvement was required.   |



## 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 the September 2021 inspection we found staff had accessed an electronic learning programme, but external training had been limited during the pandemic. Training had been completed by most staff, but the pandemic had had an impact due to the availability of staff. Training was monitored and a training plan was in place.</p> <p>At the inspection in 2022 records showed most staff had completed the required training in 2021 and staff who had not been able to complete training in 2021 had commenced refresher training. Appraisals were provided annually and were scheduled to be completed in October 2022.</p> |             |

## Coordinating care and treatment

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

| Indicator   | Y/N/Partial |
|---|-------------|
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.   | Y           |
| Patients received consistent, coordinated, person-centered care when they moved between services.   | Y           |
| <p>Explanation of any answers and additional evidence:</p> <p>The practice hosted staff employed by the local Primary Care Network (PCN) these services included:</p> <ul style="list-style-type: none"> <li>• Home Visiting Service – The PCN provided a visiting service of 10 appointments a day for the group of practices within the PCN. A paramedic was employed to undertake the visits and reported back to the practice and requested a GP if required.</li> <li>• Physio First – a physiotherapist held a clinic three times per week within the practice or via telephone, reception staff can book patients directly into these appointments.</li> </ul> |             |



## Helping patients to live healthier lives

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

|  | Y/N/Partial |
|--|-------------|
| The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.  | Y           |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health.  | Y           |
| Patients had access to appropriate health assessments and checks.  | Y           |
| Staff discussed changes to care or treatment with patients and their carers as necessary.  | Y           |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.   | Y           |
| Explanation of any answers and additional evidence:  |             |
| Patients were referred to external services, such as the Diabetes Prevention Programme, to support them to manage their long-term conditions. The PCN was also providing a dietician service for newly diagnosed patients with type 2 diabetes and a social prescriber who visited the practice once per week to assist vulnerable and lonely patients with befriending and benefits advice. |             |

## 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 Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.                           | Y           |
| Explanation of any answers and additional evidence:   |             |
| At the September 2021 inspection records relating to DNACPR decisions did not always include the DNACPR form and the decision had not always been reviewed. |             |
| At the July 2022 inspection records we reviewed contained the DNACPR form and reviews had been undertaken.  |             |

## Responsive

## Rating: Not Rated

The data and evidence we reviewed in relation to the responsive key question as part of this inspection did not suggest we needed to review the rating for responsive at this time. Responsive remains rated as good.

### Access to the service

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

*The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.*

|   | Y/N/Partial |
|---|-------------|
| Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice  | Y           |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)  | Y           |
| Patients were able to make appointments in a way which met their needs  | Y           |
| There were systems in place to support patients who face communication barriers to access treatment   | Y           |
| Patients with most urgent needs had their care and treatment prioritised  | Y           |
| There was information available for patients to support them to understand how to access services (including on websites and telephone messages)  | Y           |
| Explanation of any answers and additional evidence:<br>There was continued patient satisfaction with all aspects the practice appointments system and ease of contacting the practice by telephone which was above local and national averages. |             |

## Well-led

## Rating: Good

### Leadership capacity and capability

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

|  | Y/N/Partial |
|--|-------------|
|--|-------------|

|  |   |
|--|---|
| Leaders demonstrated that they understood the challenges to quality and sustainability.  | Y |
| They had identified the actions necessary to address these challenges.   | Y |
| Staff reported that leaders were visible and approachable.   | Y |
| There was a leadership development programme, including a succession plan.   | Y |
| Explanation of any answers and additional evidence:  |   |
| <ul style="list-style-type: none"> <li>• The improvements in oversight by the provider had been maintained and weekly meetings were held between the manager and provider. Monthly summary records of the meetings were completed, and these had been improved in terms of attendees and any agreed actions.</li> <li>• The practice manager and the provider attended the monthly Primary Care Network (PCN) meetings.</li> <li>• Staffing at the practice had remained stable but availability had been impacted by the pandemic and recent clinical staff absence, however, cover had been provided and additional staff employed.</li> <li>• The practice had continued to provide a patient focused service despite the impact on staffing and patient satisfaction with access and care and treatment had remained high.</li> <li>• The practice had recently taken on 300 new patients from a local practice which had closed. This had created a large amount of work to register these patients onto their systems. They had been reviewing these patients to ensure all their health and medication monitoring checks were up to date. They had employed additional staff to assist in this work.</li> <li>• Staff told us they felt supported.</li> </ul> |   |

## Vision and strategy

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

|   | Y/N/Partial |
|---|-------------|
| The vision, values and strategy were developed in collaboration with staff, patients and external partners.   | Y           |
| Staff knew and understood the vision, values and strategy and their role in achieving them.   | Y           |
| Progress against delivery of the strategy was monitored.  | Y           |
| Explanation of any answers and additional evidence:   |             |
| The practice had continued to focus on provision of patient centred care. Data showed the practice had maintained good outcomes for patients and high levels of patient satisfaction. |             |

## Culture

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

|  | Y/N/Partial |
|--|-------------|
|  |             |

|  |   |
|--|---|
| There were arrangements to deal with any behavior inconsistent with the vision and values.   | Y |
| Staff reported that they felt able to raise concerns without fear of retribution.  | Y |
| There was a strong emphasis on the safety and well-being of staff.   | Y |
| There were systems to ensure compliance with the requirements of the duty of candour.  | Y |
| When people were affected by things that went wrong, they were given an apology and informed of any resulting action.  | Y |
| The practice encouraged candour, openness and honesty.   | Y |
| The practice had access to a Freedom to Speak Up Guardian.   | Y |
| Staff had undertaken equality and diversity training.  | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>At the inspection in September 2021 we found the staff handbook had been updated to inform staff who to contact for their freedom to speak up guardian. Staff told us they had been informed about how to contact the freedom to speak up guardian but the policy lacked contact details.</p> <p>At the inspection in July 2022 we found the contact details had been added to the policy.</p> |   |

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

| Source               | Feedback  |
|----------------------|---|
| Staff questionnaires | <p>Staff told us they were happy working at the practice and there was good communication.</p> <p>They said they felt supported by the management and worked well as a team.</p> <p>They told us they had access to training and felt involved in the running of the practice.</p> <p>They said all staff do their best for their patients and they received good feedback from patients.</p> |

#### Governance arrangements

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

|  | Y/N/Partial |
|--|-------------|
| There were governance structures and systems which were regularly reviewed.  | Y           |
| Staff were clear about their roles and responsibilities.   | Y           |
| There were appropriate governance arrangements with third parties.   | Y           |
| <p>Explanation of any answers and additional evidence:</p> <p>Records of receipt and actions taken on safety alerts had been improved.</p> <p>We found evidence of one legacy safety alert not being fully actioned for a small number of patients.</p> <p>The provider said they would review these patients.</p> |             |

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**Managing risks, issues and performance**

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

|   | Y/N/Partial |
|---|-------------|
| There were comprehensive assurance systems which were regularly reviewed and improved.  | Y           |
| There were processes to manage performance.   | Y           |
| There was a quality improvement programme in place.   | Y           |
| There were effective arrangements for identifying, managing and mitigating risks.   | 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           |
| Explanation of any answers and additional evidence:<br><br>Systems to assess and minimise risk of COVID-19 and recent staff absences had been implemented. Individual staff risk assessments had been completed and staff had been supported in arrangements to minimise risk such as working from home and a change to duties on return to work. |             |

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

|   | Y/N/Partial |
|---|-------------|
| The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.                     | Y           |
| The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access. | Y           |
| There were systems in place to identify and manage patients who needed a face-to-face appointment.                          | Y           |
| The practice actively monitored the quality of access and made improvements in response to findings.                        | Y           |
| There were recovery plans in place to manage backlogs of activity and delays to treatment.                                  | Y           |
| Changes had been made to infection control arrangements to protect staff and patients using the service.                    |             |

|  |   |
|--|---|
|  | Y |
| Staff were supported to work remotely where applicable.  | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>There was continued patient satisfaction with all aspects the practice appointments system and ease of contacting the practice by telephone which was above local and national averages.</p> <p>During the pandemic the triage system, which was already in place for emergency on the day appointments, was extended to booking routine appointments and was still in place. Triage of patients was undertaken by the advanced nurse practitioner or GP. Systems were in place for reception staff to raise any urgent concerns about a patient's health or wellbeing to the clinicians so they could be prioritised.</p> <p>The provider told us they had a minimal back log of work to complete following the pandemic however, they had recently had a sudden cohort of 300 patients registering with them following the closure of another practice. They had employed additional staff to address the needs of these patients.</p> |   |

## 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           |
| Explanation of any answers and additional evidence:  |             |
| The practice used information and data to check progress against targets and information from national surveys to assess patient satisfaction. |             |

## Governance and oversight of remote services

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

## Engagement with patients, the public, staff and external partners

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

|  | Y/N/Partial |
|--|-------------|
| Patient views were acted on to improve services and culture.   | Y           |
| The practice had an active Patient Participation Group.  | N           |
| Staff views were reflected in the planning and delivery of services.   | Y           |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Y           |

Explanation of any answers and additional evidence:

- At the August 2019 and September 2021 inspection we recommended the practice review and improve patient engagement as the provider did not have a patient participation group (PPG) and the practice manager told us they had little interest from patients to form a PPG. A notice was displayed in the waiting room asking patients to become involved.

At the July 2022 inspection we found:

- The provider did not have a patient participation group (PPG) and the practice manager told us they had still had little interest from patients to form a PPG. They were now trying to approach individual patients directly.
- The practice had a friends and family test (FFT) survey box in the waiting area where they collected handwritten feedback from patients and patients could also access FFT online. Data from the FFT survey was all positive. We observed 33 recently completed FFT forms which all included positive comments about the care and treatment, staff who they described as kind, caring and helpful and the ease of access.
- The practice was signed up to the online Rotherham health application (app). The Rotherham health app is a brand-new service providing online access for patients to manage their healthcare 24 hours a day, book appointments, check symptoms, manage medication, view test results and access their medical record.

## Continuous improvement and innovation

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

|  | Y/N/Partial |
|--|-------------|
| There was a strong focus on continuous learning and improvement. | Y           |
| Learning was shared effectively and used to make improvements.   | Y           |

Explanation of any answers and additional evidence:

- We found the nursing team had been encouraged to access external training and support relevant to their role and staff training had been encouraged and monitored. A nurse was due to commence an advanced clinical practice course. Whilst there had been an impact on staff training during the pandemic the practice manager had monitored this and worked with staff to



support them to catch up.

- The practice manager had been proactive in addressing areas identified for improvement at the last inspection.

### Examples of continuous learning and improvement

- The practice was in the process of developing a new recall system to improve effectiveness and was setting up a pilot for diabetic recalls which was to be extended to other areas if successful.
- The nursing team had been involved in the clinical audits to improve care and treatment to look at gestational diabetes follow ups.

## 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)     | $\leq -3$              |
| Variation (positive)                 | $> -3$ and $\leq -2$   |
| Tending towards variation (positive) | $> -2$ and $\leq -1.5$ |
| No statistical variation             | $< 1.5$ and $> -1.5$   |
| Tending towards variation (negative) | $\geq 1.5$ and $< 2$   |
| Variation (negative)                 | $\geq 2$ and $< 3$     |
| Significant variation (negative)     | $\geq 3$               |

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.