

Care Quality Commission

Inspection Evidence Table

The Elms Medical Practice (1-583860615)

Inspection date: 6 and 7 December 2022

Date of data download: 17 November 2022

Overall rating: Requires Improvement

We rated the practice as Requires Improvement overall because:

- Some improvements were required to infection prevention and control systems and processes.
- Most risks to patients, staff and visitors were assessed, monitored or managed effectively. However, the provider did not have all emergency equipment that was required to be kept.
- The arrangements for managing medicines did not always keep patients safe.
- Improvements were required to some types of patient reviews.
- Processes for managing risks, issues and performance required improvement.

Safe

Rating: Requires Improvement

We rated the practice as Requires Improvement for providing safe services because:

- Some improvements were required to infection prevention and control systems and processes.
- Most risks to patients, staff and visitors were assessed, monitored or managed effectively. However, the provider did not have all emergency equipment that was required to be kept.
- The arrangements for managing medicines did not always keep patients safe.

Safety systems and processes

The practice's systems, practices and processes helped keep people safe and safeguarded from abuse.

Safeguarding	
There was a lead member of staff for safeguarding processes and procedures.	Yes
Policies and other documents covering adult and child safeguarding were accessible to all staff. They clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare.	Yes
GPs and staff were trained to appropriate levels for their role and knew how to identify and report concerns.	Yes
The practice worked in partnership with other agencies to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. Information about patients at risk was shared with other agencies in a timely manner.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
Notices in the practice advised patients that chaperones were available if required.	Yes
Additional evidence or comments	
The practice's computer system alerted staff of children that were on the risk register. We looked at the records of four such children and found that the practice's computer system did not alert staff to all family and other household members of these children. However, during our inspection the provider addressed these findings and we saw alerts had been added to all family and other household members of these children.	

Recruitment systems	
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes

There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
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Safety systems and records	
There were up to date fire risk assessments that incorporated an action plan to address issues identified.	Yes
The practice had a fire evacuation plan.	Yes
Records showed fire extinguishers were maintained in working order.	Yes
Records showed that the practice carried out fire drills.	Yes
Records showed that the fire alarm system was tested regularly.	Yes
The practice had designated fire marshals.	Yes
Staff were up to date with fire safety training.	Yes
All electrical equipment was checked to help ensure it was safe to use.	Yes
All clinical equipment was checked and where necessary calibrated to help ensure it was working properly.	Yes

Infection prevention and control

There were systems and processes to help maintain appropriate standards of cleanliness and hygiene. However, some improvements to infection prevention and control were required.

We observed the premises to be clean and all areas accessible to patients were tidy.	Yes
There was a lead member of staff for infection prevention and control who liaised with the local infection prevention teams to keep up to date with best practice.	Yes
There was an up to date infection prevention and control policy.	Yes
There was an up to date infection prevention and control audit that incorporated an action plan to address issues identified.	Partial
Relevant staff were up to date with infection prevention and control training.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes

Additional evidence or comments

We found pull cords used to operate the light and the extractor fan in two of the toilets were dirty and not able to be cleaned. These represented a source of infection to anyone that used them. This had not been identified by the Infection Prevention and Control (IPC) audit.

We looked at three clinical rooms and found two contained clinical wash-hand basins that had overflows and plugs. This was not in line with best practice guidance for the prevention and control of infection. This had not been identified by the IPC audit, but replacement of these clinical wash-hand basins was listed in the infection control action monitoring plan. However, the plan did not contain a planned date by when the basins were to be replaced. The plan also indicated that action had been

taken to address IPC issues in the kitchen and room four. However, the comments column of the plan stated that flooring needed replacing in these two areas but did not indicate when this would be carried out.

Risks to patients, staff and visitors

Most risks to patients, staff and visitors were assessed, monitored or managed effectively. However, the provider did not have all emergency equipment that was required to be kept.

The provider had systems to monitor and review staffing levels and skill mix.	Yes
There was an effective approach to managing staff absences and busy periods.	Yes
Staff knew how to respond to emergency situations.	Yes
All staff were up to date with basic life support training.	Yes
Emergency equipment and emergency medicines were available in the practice including medical oxygen and an automated external defibrillator (AED).	Partial
Records showed that emergency equipment and emergency medicines were checked regularly.	Yes
Emergency equipment and emergency medicines that we checked were within their expiry dates.	Yes
There was up to date written guidance for staff to follow in the event of major incidents that contained emergency contact telephone numbers.	Yes
There was written guidance for staff to follow to help them identify and manage deteriorating or acutely unwell patients.	Yes
Staff were up to date with training in how to identify and manage patients with severe infections. For example, sepsis.	Yes
There were a variety of health and safety risk assessments that incorporated action plans to address issues identified.	Yes
There was an up to date health and safety policy available with a poster in the practice which identified local health and safety representatives.	Yes
There was an up to date legionella risk assessment and an action plan to address issues identified.	Yes
Additional evidence or comments	
We looked at emergency equipment and emergency medicines held at the practice. We found the provider did not have all emergency equipment that was required to be kept. For example, a spare set of adult defibrillation pads were not available. The provider had also not carried out a risk assessment of not keeping this equipment for use in an emergency.	

Information to deliver safe care and treatment

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

Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented.	Yes
The practice had a documented approach to the management of test results, and this was managed in a timely manner.	Yes
The practice demonstrated that when patients used multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
Additional evidence or comments	
The provider had carried out an audit of the referral of patients to secondary services under the two week wait process during the period July to September 2022. Results showed 154 patients were referred during this time but 40% had not been captured on the practice's monitoring spreadsheet. Action was taken to address these findings and the audit repeated for the period October to November 2022. Although results demonstrated an improvement they also showed that 22% had not been captured on the practice's monitoring spreadsheet. Records showed further action was planned to help address these findings including ongoing monitoring of improvements.	

Appropriate and safe use of medicines

The arrangements for managing medicines did not always keep patients safe.

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	1.15	0.85	0.82	Tending towards variation (negative)
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). (01/07/2021 to 30/06/2022) (NHSBSA)	9.9%	8.9%	8.5%	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
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 (01/01/2022 to 30/06/2022) (NHSBSA)	6.13	5.77	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	158.0‰	132.5‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	1.75	0.61	0.59	Variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	6.2‰	6.8‰	6.8‰	No statistical variation

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

Medicines management	
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescription forms and pads were kept securely, and their use monitored in line with national guidance.	No
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	No
There was a process for monitoring patients' health in relation to the use of medicines including high-risk medicines with appropriate monitoring and clinical review prior to prescribing.	No
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Yes
Up to date local prescribing guidelines were in use.	Yes
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.	Yes
Additional evidence or comments	
At the time of our inspection NHSBSA published results showed that the practice was performing in line with most local and England averages when prescribing some antibiotics and some hypnotics.	

Medicines management

Where performance deviated negatively from these averages, we saw the provider was taking action to make improvements. For example, a medicines optimisation audit on the topic of antibiotics had been carried out and an action plan made to help improve performance. Records showed there were plans to repeat the audit to establish the effectiveness of the action plan.

Blank prescription forms were not tracked through the practice when taken from storage. Staff told us they were left in computer printers overnight. Although doors to rooms where blank prescription forms were left in printers overnight were kept locked, this was not in line with best practice guidance.

We looked at five patient group directions (PGDs) used by nursing staff to administer vaccinations. We found four had not been completed correctly. For example, blank areas had not been crossed through (to prevent the addition of more staff names after the authorising manager had signed the PGD). The organisation name had also not been added to the PGDs. More staff names had been added to two of the PGDs after the authorising manager had signed them. Although the addition of staff names had been initialed by the authorising manager, this was not in line with best practice guidance for completion and use of PGDs.

During our inspection we looked at the records of:

- Five patients who were prescribed warfarin. Records showed relevant blood tests were being carried out prior to the prescribing of this high-risk medicine for four of these patients. However, none of these patients' records contained details of the date their next blood test was due. One of these patients' records showed their last blood test result was recorded on 26 May 2020 and they had been prescribed warfarin on 14 October 2022. This was not in line with best practice guidance for the management of this high-risk medicine.
- Five patients who were prescribed methotrexate. Records showed that two of these patients were overdue some relevant blood tests at the time the practice last prescribed methotrexate for them. This was not in line with best practice guidance for the management of this high-risk medicine.
- One patient who was prescribed lithium. Records showed this patient was overdue relevant blood tests at the time the practice last prescribed lithium for them. This was not in line with best practice guidance for the management of this high-risk medicine.
- One patient who was prescribed benzodiazepine. We looked but could not find evidence to show the risks of taking this medicine had been discussed with the patient. Records showed this patient was also prescribed zopiclone. This was not in line with best practice guidance for the management of this high-risk medicine.
- One patient who was prescribed zopiclone. We looked but could not find evidence to show this patient had received an up to date review nor that a risk assessment of the regular prescribing of this medicine had been carried out. This was not in line with best practice guidance for the management of this high-risk medicine.

The provider was responsive to our findings and wrote to us after our inspection to tell us:

- They planned to switch to using due dates in patients' records instead of time intervals when recording when blood tests were next due for patients who were prescribed warfarin.
- They planned to refine their protocol for the prescription of methotrexate and improve documentation particularly for those patients whose blood test results were stored on external systems.
- They planned to take appropriate action to encourage patients who were prescribed lithium to attend for relevant blood tests in line with best practice guidance.

Dispensary services (where the practice provided a dispensary service)	
There was a GP responsible for providing effective leadership for the dispensary.	Yes
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Yes
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Yes
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Yes
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Partial
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Yes
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	N/A
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	N/A
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Yes
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	No
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes
Additional evidence or comments	
<p>The provider had recently reviewed their standard operating procedures (SOPs) for all dispensary tasks. However, some links in the SOP documentation to references had not been updated.</p> <p>Patient returned controlled drugs were not always disposed of in line with legislation. However, the provider was responsive to our findings and rectified this during our inspection.</p> <p>Staff lacked knowledge regarding the accessible information standard and relied upon patients' family members or representatives to support them. Not all dispensary staff we spoke with were aware of the practice having a hearing loop.</p>	

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
There was a system for recording and acting on significant events.	Yes

There was written guidance available for staff to follow to help them identify, report and manage any significant events.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses both internally and externally.	Yes
Number of events recorded in last 12 months:	5
Records showed that the practice had carried out a thorough analysis of reported significant events.	Yes
There was evidence of learning and dissemination of information from significant events.	Partial

Additional evidence or comments

We looked at the records of one significant event that had been recorded as taking place at The Elms Medical Practice. We saw details of the event reported by staff had been investigated, and necessary action taken. Records summarised the learning to be taken from the significant event. For example, written instructions were now required when changes to patients' medicines were requested by other services. Other records demonstrated that such requests were being received and saved into relevant patients' records. However, we asked to see evidence of learning from significant events being shared with relevant staff but were not provided with any.

Safety alerts	
The practice had systems for managing safety alerts.	Yes
Information from safety alerts was shared with staff.	Yes
Staff understood how to deal with safety alerts.	Yes
The practice acted on and learned from safety alerts.	Yes
The practice kept records of action taken (or if no action was necessary) in response to receipt of all safety alerts.	Yes

Additional evidence or comments

During our clinical searches, we reviewed two safety alerts and found that both had been managed appropriately.

Effective

Rating: Requires Improvement

We rated the practice as Requires Improvement for providing effective services because:

- Improvements were required to some types of patient reviews.

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 not always assessed, and care as well as treatment were not always delivered in line with current legislation, standards and evidence-based guidance.

The practice had systems and processes to help keep clinicians up to date with current evidence-based practice.	Yes
Staff had access to guidance from NICE and used this information to deliver care and treatment that met patients' needs.	Yes
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.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
Additional evidence or comments	
Patients with some long-term conditions, such as mental health conditions and patients receiving palliative care were receiving relevant reviews. However, we found that improvements were required to some reviews of patients with asthma, chronic obstructive pulmonary disease (COPD), diabetes, hypertension, atrial fibrillation (AF) and dementia.	

Monitoring care and treatment

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

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

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. Influenza, 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. Chlamydia screening was available for relevant patients. Patients with suspected hypertension were offered ambulatory blood pressure monitoring. All patients with a learning disability were offered an annual health check. 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. 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 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 looked at the records of:

- Five patients who were diagnosed with asthma. Records showed one of these patients had not received a review since 2017 and another had not received a review since 2019. Another patient's records showed they had received an asthma review in December 2022, but their blood pressure had not been recorded since January 2020. This was not in line with best practice guidance for the management of this long-term condition.
- Five patients who were diagnosed with chronic obstructive pulmonary disease (COPD). However, we looked but could not find any evidence to show that three of these patients' reviews followed best practice guidance (Global Initiative for Chronic Obstructive Lung Disease – GOLD guidance).
- Five patients who were diagnosed with diabetes. Records showed all of these patients had received a review within the last 12 months. However, two of these patients were overdue other monitoring, such as other relevant blood tests, and one had not had a foot check since 2019. This was not in line with best practice guidance for the management of this long-term condition.
- Five patients who were diagnosed with hypertension. Records showed one of these patients had not received a review since 2019. Another of these patients' records showed a high blood pressure reading had been captured in their records in April 2022. However, we looked but could not find evidence to show the practice had taken any action in response to this reading. This was not in line with best practice guidance for the management of this long-term condition.
- Five patients who were diagnosed with atrial fibrillation (AF). Records showed one of these patients had not received a review since 2016 and no blood pressure result had been captured in their records in the last five years. Three of these patients were overdue relevant blood tests and one had not had their blood pressure recorded since 2020. This was not in line with best practice guidance for the management of this long-term condition.
- Five patients who were diagnosed with mental health conditions. Records showed all of these patients had received a review in line with best practice guidance for the management of this long-term condition.
- Five patients who were diagnosed with dementia. Records showed one of these patients was overdue relevant blood tests. Another of these patients was overdue relevant blood tests and blood pressure monitoring. Another was overdue blood pressure monitoring. This was not in line with best practice guidance for the management of this long-term condition.
- We looked at the records of five patients who were receiving palliative care and found that end of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

The provider was responsive to some of our findings and wrote to us after our inspection to tell us:

- They planned to review documentation of COPD reviews to help ensure justification for any potential deviation from best practice guidance was recorded in relevant patients' records.

Staff who were responsible for reviews of patients with long-term conditions had received specific training.

GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.

We completed a series of searches on the practice's clinical record system. These searches were completed to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance. Our searches showed the practice identified

patients with commonly undiagnosed conditions. For example, diabetes or chronic kidney disease (CKD). However, our searches also showed there were 171 patients who were prescribed angiotensin converting enzyme inhibitor medicine or angiotensin II receptor blocker medicine who had not had relevant blood tests carried out in the last 18 months. After our inspection the provider wrote to us and told us these patients had been invited to attend for relevant blood tests but had not done so. The provider planned to review their processes to manage non-compliance of attendance for relevant blood tests by these patients.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	97	106	91.5%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	106	120	88.3%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	105	120	87.5%	Below 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)	106	120	88.3%	Below 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)	122	126	96.8%	Met 95% WHO based target

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

Additional evidence or comments

Childhood immunisations were carried out in line with the national childhood vaccination programme. NHS England results (published in March 2021) showed that uptake rates were above the WHO based target of 95% in one out of the five indicators. However, results also showed uptakes rates were below the target of 90% in three out of the five indicators. The provider was aware of these performance results and were taking action to increase uptake of childhood immunisations. For example, two designated staff ran searches of the practice's computer system regularly to help identify children who were overdue childhood vaccinations. Parents of these children were contacted by staff to encourage attendance at appointments where children could receive vaccinations. The health visitor was also contacted to help encourage attendance for childhood vaccinations.

After our inspection the provider wrote to us with unverified data that showed the practice had met the minimum target of 90% for the three indicators as at 21 January 2023.

Cancer Indicators	Practice	SICBL 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: 30/06/2022) (UK Health and Security Agency)	71.6%	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)	33.5%	63.4%	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)	65.3%	68.0%	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)	60.0%	56.4%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Additional evidence or comments

Published results showed that the practice's uptake for cervical screening as at June 2022 was below the 80% coverage target for the national screening programme. However, unverified data showed uptake of cervical screening by eligible patients was to date:

- 82% for patients aged 25 to 49 years.
- 83% for patients aged 50 to 64 years.

Published results showed that the practice's uptake for breast cancer screening was below local and England averages. The provider was aware of this performance and had developed a written action plan to help increase uptake. Implementation of this was ongoing at the time of our inspection. After our

inspection the provider wrote to and provided unverified data that showed the practice's attainment for breast cancer screening in 2020 to 2021 was 54.3% and for 2021 to 2022 was 61.9%.

Published results showed that the practice's uptake for bowel cancer screening was in line with local and England averages.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

There was an induction programme for new staff.	Yes
The learning and development needs of all staff were assessed.	Yes
All staff were up to date with essential training.	Yes
All staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation.	Yes
Clinical staff were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice.	Yes
There was a clear approach for supporting and managing staff when their performance was poor or variable.	Yes

Coordinating care and treatment

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

Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centered care when they moved between services.	Yes

Helping patients to live healthier lives

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

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.	Yes

Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health. For example, stop smoking campaigns and tackling obesity.	Yes

Consent to care and treatment

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

Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgmental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

National GP Patient Survey Results published in July 2022

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	76.2%	82.1%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	77.8%	80.8%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	92.9%	92.0%	93.1%	No statistical variation

The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	53.5%	66.8%	72.4%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	92.2%	89.0%	89.9%	No statistical variation

Additional evidence or comments

Feedback about the practice from the national GP patient survey published in July 2022 regarding care and treatment was mostly in line with local and England averages. However, feedback regarding patients' overall experience of their GP practice was tending towards variation negative.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 205 (2%) patients who were carers.
How the practice supported carers (including young carers).	Carers were identified during the registration process and during consultations. There was also a carers' notice in the waiting room. Patients identified as being cared for were also asked who their carers were in order to help the practice identify carers. Patients who were carers were able to be referred to other services who could advise and arrange relevant packages of support.
How the practice supported recently bereaved patients.	Bereaved patients were offered appointments with the practice's wellbeing practitioner or social prescriber to speak about their bereavement. Relevant leaflets were available and bereaved patients were directed to bereavement support services.

Privacy and dignity

The practice respected patients' privacy and dignity.

A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes

Responsive

Rating: Good

Responding to and meeting people's needs

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

The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements for people who need translation services.	Yes
All patients had been allocated to a designated GP to oversee their care and treatment.	Yes
The practice complied with the Accessible Information Standard.	Yes

Further information about how the practice is responding to the needs of their population
<p>Patients had a named GP who supported them in whatever setting they lived.</p> <p>The practice was responsive to the needs of older patients and offered urgent appointments for those with enhanced needs and complex medical issues.</p> <p>The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.</p> <p>Appointments were available outside of school hours so that school age children did not need to miss school in order to receive care and treatment.</p> <p>The practice held a register of patients living in vulnerable circumstances including those with a learning disability.</p> <p>People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travelers.</p> <p>Services were provided to patients who were residents in local care homes / residential homes.</p> <p>The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.</p> <p>Patient toilets were available that included ones that were suitable for use by people with mobility issues.</p>

Purpose built baby changing facilities were available.

A hearing loop was available at the practice reception to assist patients who were hard of hearing or deaf.

Signs were displayed informing mothers who wished to breastfeed that this was supported by the practice and a private room would be made available for them to use if required.

The provider was in the process of extending the premises at The Elms Medical Practice to increase capacity. The building work was scheduled to be completed in April 2023.

Access to the service

People were able 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.

Practice Opening Times	
The Elms Medical Practice	
Day	Time
Monday	9am to 6pm
Tuesday	9am to 6pm
Wednesday	9am to 6pm
Thursday	9am to 6pm
Friday	9am to 6pm
Alternate Saturdays	9am to 12pm
Allhallows branch surgery	
Day	Time
Monday	9am to 6pm
Tuesday	3.30pm to 5.30pm
Wednesday	9am to 5pm
Thursday	3.30pm to 5.30pm

Friday	8.30am to 6pm
Grain branch surgery	
Day	Time
Monday	8.30am to 12pm
Tuesday	Closed
Wednesday	8.30am to 12pm
Thursday	Closed
Friday	8.30am to 12pm
High Halstow branch surgery	
Day	Time
Monday	2pm to 2.50pm
Tuesday	Closed
Wednesday	Closed
Thursday	9am to 9.40am
Friday	9am to 9.50am

There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes
Patients were able to make appointments in a way which met their needs.	Yes
Patients had timely access to appointments / treatment and action was taken to minimize the length of time people waited for care, treatment or advice.	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes
There were systems to support patients who face communication barriers to access treatment.	Yes
Patients with the most urgent needs had their care prioritised.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours.	Yes
There were systems to monitor the quality of access and make improvements.	Yes
Additional evidence or comments	
Patients were able to book appointments by telephone, online and in person.	
The practice's website made provision for people with impairments. For example, people with dyslexia.	
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	

The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.

There were arrangements with other providers to deliver home visits as well as services to patients outside of the practice's working hours. Although home visits were also provided by practice staff when necessary.

Influenza and covid vaccinations were provided to eligible patient if required during some home visits.

We looked at the practice's appointments system and saw that the next available face to face appointment with a GP was 7 December 2022 and the next available face to face appointment with a nurse was 7 December 2022.

National GP Patient Survey Results published in July 2022

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	37.9%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	41.8%	48.6%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	35.7%	48.2%	55.2%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	63.8%	68.2%	71.9%	No statistical variation

Additional evidence or comments

Feedback about the practice from the national GP patient survey published in July 2022 regarding access was mostly in line with local and England averages. However, feedback regarding patients' satisfaction with appointments times was tending towards variation negative.

The practice was aware of these results and was taking action to help improve patient satisfaction scores. For example, the number of face to face appointments had recently been increased to improve availability of appointments for patients to book into. Staff were taking time to explain the practice's

system of assessing patients' needs in order to allocate them to the most appropriate type of appointment with the most appropriate clinician. For example, a telephone appointment with an advanced nurse practitioner or a face to face appointment with a GP or paramedic. Staff told us the practice was in the process of monitoring the effectiveness of these actions on patient satisfaction scores.

Listening and learning from concerns and complaints

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

Complaints	
The practice had a system for handling complaints and concerns.	Yes
The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.	Yes
Information was available to help patients understand the complaints system.	Yes
Number of complaints received in the last 12 months.	7
Additional evidence or comments	
We looked at the records of one complaint reported within the last 12 months. Records showed that this complaint had been acknowledged and, after investigation, replied to in writing. Records also showed that learning from the complaint had been shared with relevant practice staff who had subsequently reflected on their practice to help improve patient experience during care and treatment delivered in the practice.	

Well-led

Rating: Requires Improvement

We rated the practice as Requires Improvement for providing well-led services because:

- Processes for managing risks, issues and performance required improvement.

Leadership, capacity and capability

There was compassionate and inclusive leadership at all levels.

Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
Leaders had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Yes
Additional evidence or comments	
Clinical leadership including clinical supervision was provided by the GP partners.	
Our inspection identified that improvements were required to the management of some risks as well as for some types of patient reviews and subsequent follow-up activities. After our inspection the provider wrote to us and told us that action had been taken to address some of these issues. Additionally, they wrote and told us that during the pandemic the practice contributed to the Covid vaccination initiative which may have partially compromised their capacity for chronic disease and medicines monitoring during that time.	
Staff told us that the GP partners and practice management were approachable and always took time to listen to all members of staff.	

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients.

The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes

Additional evidence or comments

The provider had a statement of purpose which reflected the visions of the practice.

Culture

The practice had a culture of high-quality sustainable care.

Staff told us there was an open culture within the practice and they felt confident and supported to raise any issues.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
Additional evidence or comments	
Staff told us they felt respected, valued and supported locally by the practice and by their colleagues.	

Governance arrangements

There were processes and systems to support good governance and management.

There was a clear staffing structure and staff were aware of their own roles and responsibilities.	Yes
The provider had systems that helped to keep governance documents up to date.	Yes
Governance documents that we looked at were up to date.	Yes

Managing risks, issues and performance

Processes for managing risks, issues and performance were not always effective.

There were effective arrangements for identifying, recording, managing and mitigating risks.	Partial
There were processes to manage performance.	Partial
Clinical and internal audit was used to monitor quality and to make improvements.	Yes
Records showed that the provider had analysed all clinical audit results and implemented action plans to address findings.	Yes
Records showed that all clinical audits had been repeated or were due to be repeated to complete the cycle of clinical audit.	Yes

There was written guidance for staff to follow in the event of major incidents that contained emergency contact telephone numbers.	Yes
Additional evidence or comments	
<p>Our inspection identified that improvements were required in relation to the management of risks from:</p> <ul style="list-style-type: none"> • All identifiable infection prevention and control issues. • Not having all emergency equipment that was required to be kept. • The lack of tracking blank prescription forms through the practice when taken from storage. • The lack of some Patient Group Directions not being completed correctly. • Some high-risk medicines prescribing. <p>After our inspection the provider wrote to us and told us action had been taken to address some of these issues.</p> <p>We found that improvements to care and treatment were required for some types of patient reviews as well as subsequent follow-up activities. For example, asthma reviews, chronic obstructive pulmonary disease (COPD) reviews, diabetes reviews, hypertension reviews, atrial fibrillation (AF) reviews and dementia reviews. Improvements were also required to the monitoring of some patients who were prescribed angiotensin converting enzyme inhibitor medicine or angiotensin II receptor blocker medicine.</p> <p>After our inspection the provider wrote to us and told us action had been taken to address some of these issues.</p>	

The provider had systems to continue to deliver services, respond to risk and meet patients' needs during the pandemic.

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

Appropriate and accurate information

The practice acted on appropriate and accurate information.

Quality and operation information was used to help monitor and improve performance.	Yes
The provider submitted data or notifications to external organisations as required.	Yes
There were arrangements in line with data security standards for the integrity and confidentiality of patient identifiable data, records and data management systems.	Yes

Governance and oversight of remote services

The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to help ensure they delivered high-quality and sustainable care.

Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group (PPG).	Yes
The practice gathered feedback from patients through the PPG.	Yes
The practice gathered feedback from patients through analysis of the results of the national GP patient survey.	Yes

Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes

Additional evidence or comments

The practice monitored feedback received from the national GP patient survey and were taking action to improve patient satisfaction scores.

In response to patient feedback the practice had taken back all contracted operating hours from their out of hours provider and was now answering telephone calls from 8am to 6.30pm with clinicians present throughout this time.

Staff told us they felt respected, valued and supported locally by the practice and by their colleagues.

Experience shared with CQC directly via our website

Total received	6
Number received which were positive about the service	2
Number received which were mixed about the service	0
Number which were negative about the service	4

Reviews left on the NHS Choices website

Total reviews	0
Number of reviews that were positive about the service	0
Number of reviews that were mixed about the service	0
Number of reviews that were negative about the service	0

Examples of feedback received

Examples of feedback received	Source
<p>Feedback we received from patients about services at The Elms Medical Practice was mixed.</p> <p>There were no common themes identified from reviews left on the NHS Choices website or in feedback we received.</p>	<p>Reviews left on the NHS Choices website and experience shared with CQC directly via our website over the last 12 months.</p>

Continuous improvement and innovation

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

The practice made use of reviews of incidents.	Yes
Learning was shared and used to make improvements.	Yes
Additional evidence or comments	
Significant events and complaints were used to make improvements and any learning shared with relevant staff at this practice. For example, systems and processes had been revised to help reduce the risk of errors when changes to patients' medicines were requested by services outside of the practice.	
The provider participated in the GP attraction initiative to help recruit additional GPs.	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a SICBL 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 SICBL 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.