

Inspection Evidence Table

Royal Manor Health Care

(1-542083677)

Inspection Date: 3 August 2023

Date of data download: 26/07/2023

Overall rating: Good

At the last inspection in May 2022, we rated the practice as requires improvement overall. At this inspection we rated the practice as good overall, as significant improvements were made.

Safe

Rating: Good

At our last inspection in May 2022, we rated this key question as requires improvement. At this inspection, we rated this key question as good, as improvements have been made. However, the provider should:

- Develop systems to evidence all staff vaccinations are maintained in line with the current guidance.
- Implement systems to provide care navigation staff with appropriate training, information and confidence in handling calls with patients to ensure efficient and equal access to care and treatment for all patients.

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.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
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.	Yes
Explanation of any answers and additional evidence:	

The practice had appropriate systems and processes to keep people safe from harm and abuse. At the time of the inspection, we saw not all of the clinical staff were up to date with their Level 3 safeguarding. However, the provider showed us evidence to demonstrate particular members of staff were booked for face-to-face courses and we were assured that despite a delay in training, all staff will have appropriate training in safeguarding.

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.	Partial
Explanation of any answers and additional evidence: At this inspection, we found that not all staff vaccinations were maintained in line with the current guidance. 3 out of 24 clinical staff members have not had their full vaccination status recorded. Everyone who had direct contact with patients should be up to date with their immunisation. After the inspection, a record of the staff's vaccination status was sent to us and gaps were recognised. The provider was working on collecting all the records from staff.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes
Date of last assessment: 24 April 2023	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 26 November 2021	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: The practice had appropriate safety systems and processes in place. We saw evidence of fire risk assessment for both the main location (Royal Manor) and the branch surgery (The Gatehouse Surgery). We saw evidence of regular fire drills and staff reported to us they took part in it. They told us there were 2 recent fire drills, as the first one wasn't completed in an efficient amount of time, therefore it was repeated to maximise the effectiveness. The practice had several risk assessments in place, for example, one for the presence of asbestos in the building and lone working. Liability insurance was in place.	

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.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit: August 2023	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes

The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had systems and processes in place to ensure Infection Prevention and Control (IPC) standards were met. They had several audits and risk assessments in place, for example, hand hygiene audits, monthly environmental cleanliness checks and room equipment cleaning schedules. We saw evidence of the annual IPC statement and we discussed the need to follow practices own policy when meeting the IPC standards.</p>	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
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.	Partial
There were enough staff to provide appointments and prevent staff from working excessive hours.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the time of the inspection, we were not assured that all care navigators received consistent training on how to deal with unwell patients. We saw evidence of the practice's policies and procedures. For example, appointment booking, chest pain protocol, and telephone protocol and staff were aware of these. Care navigators told us they used their experience when dealing with patients and clinical support was available. However, there was no formalised training. We spoke with the provider at the feedback following the site visit and discussed the need to have a training and consistent approach when dealing with patients, especially those acutely unwell or in urgent cases.</p>	

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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes

There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence: Review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients.	

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.89	0.93	0.91	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). (01/04/2022 to 31/03/2023) (NHSBSA)	5.2%	8.3%	7.8%	Tending towards variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2022 to 31/03/2023) (NHSBSA)	5.58	5.16	5.23	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	120.9‰	105.4‰	129.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA)	0.49	0.55	0.55	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA)	8.6‰	7.3‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes

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.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines. 1	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
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. 2	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
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.	Yes
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
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>The provider was able to demonstrate that it remained safe to prescribe medicines to patients where specific, frequent, monitoring was required. For example, our remote clinical search found 139 patients over 70-year-old, who were prescribed NSAID (non-steroidal anti-inflammatory drugs) or anticoagulant medication but had not had PPI (proton pump inhibitors, medicine used to reduce stomach acid production) to protect their stomachs. The provider explained that they had a procedure in place to review those patients and were in the process of doing it. At the time of the inspection, the provider showed us the evidence of patients being reviewed and medication reviews being conducted. We were assured that the provider had an ongoing monitoring system in place to support those patients.</p> <p>All patients who were prescribed disease-modifying antirheumatic drugs (DMARDs), a high-risk medicine used in the treatment of for example, rheumatoid arthritis had required monitoring in place.</p>	

Track record on safety and lessons learned and improvements made
The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	21
Number of events that required action:	1

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

Event	Specific action taken
Incorrect patient added to triage list (same name, different spelling).	<ul style="list-style-type: none"> • Incorrect patient was rung, and situation explained. • All staff reminded of 3-point check when in contact with patient. • Data breach reported.
Medication audit picked up a patient whose medication was stopped a month prior.	<ul style="list-style-type: none"> • Patient contacted. • Investigation conducted, including contacting a consultant who stopped the medication. • Prescription re-issued within 24 hours.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. 1	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: We saw examples of actions taken on recent alerts, for example, co-prescription of clopidogrel and omeprazole. We saw evidence to demonstrate the practice had a discussion with patients about the risk of taking these medicines together.	

Effective

Rating: Good

At our last inspection in May 2022, we rated this key question as requires improvement. At this inspection we rated this key question as good, as required improvements have been made.

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 were 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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated. ³	Yes
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
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Yes
The practice prioritised care for their most clinically vulnerable patients.	Yes

Effective care for the practice population

Findings
<ul style="list-style-type: none">• 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.

- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For example, our clinical search identified 459 patients with hypothyroidism (a condition where an underactive thyroid does not produce enough hormones causing, for example, fatigue and weight gain). Three of those patients were identified as not having appropriate monitoring in the last 18 months, however, the practice was aware of those 3 patients and presented us with the evidence of either having managed appropriate monitoring or attempts to follow-up. We were assured that the practice had appropriate systems and processes to ensure appropriate monitoring was in place.
- The clinical searches identified that 20 out of 70 patients who were prescribed potassium-sparing diuretics did not have required monitoring in place. The practice was aware of this and had a process was in place to manage this for these patients. At the time of the site visit, they presented us with evidence of those patients being reviewed or having appropriate blood tests and follow-up appointments booked.
- We reviewed a random sample of 5 records of 982 patients with diabetic retinopathy and found that all had satisfactory reviews of their long-term condition managed in line with recommended guidance.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up with patients who had received treatment in a hospital or through out-of-hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example, diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	78	79	98.7%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	110	116	94.8%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	109	116	94.0%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	110	116	94.8%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	133	145	91.7%	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>

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	58.2%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	73.6%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (12/31/2022 to 12/31/2022) (UKHSA)	74.6%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	48.9%	58.5%	54.9%	No statistical variation

Any additional evidence or comments

The practice was below the 80% national target for cervical cancer screening for eligible patients. However, we were presented with unverified data from the practice, that showed that the uptake had improved to 81% for people aged 25-49 and 82% for people aged 50 – 64.

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.	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
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>The provider took part in the Primary Care Network's (PCN) SABA (short-acting beta agonist, a drug used to improve symptoms of COPD) overuse audit. Overuse of SABA increases the risk of flare-ups and asthma-related deaths. Therefore, they should be used to relieve symptoms only and be infrequent. From June 2022 to April 2023 the practice was able to engage with patients and the percentage of patients using SABA inhalers had gone down from 12% to 3%.</p> <p>The provider took part in Quality Improvement with the Chronic Pain Team in their PCN to reduce the use of opiate prescribing. The practice focused on liquid morphine prescriptions. The goal was to reduce those prescriptions by 10% over 12 months. The project started in December 2022, and there were already significant improvements. Out of 92 patients with liquid morphine prescriptions 49 were stopped. Patients were reviewed and had 3-month checks, the policy was updated, and staff were educated in this area.</p>	

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.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes

There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
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Coordinating care and treatment

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

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred 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.

	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.	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 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.	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. 1	Yes
Explanation of any answers and additional evidence: Our review of notes where a DNACPR decision had been recorded, identified that where possible the patients' views had been sought and respected. We saw that information had been shared with relevant agencies.	

Caring

Rating: Good

At our last inspection in May 2022, we rated this key question as requires improvement. At this inspection we rated this key question as good, as required improvements have been made.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

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

Patient feedback	
Source	Feedback
Friend and Family Survey – June 2023	Majority of positive feedback, comments included: <ul style="list-style-type: none">• “Very friendly staff, very efficient”• “The nurse was very helpful and did her job thoroughly and knowable”.• “Appointment straight away and the correct treatment”

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2023 to 30/04/2023)	89.7%	89.7%	85.0%	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 (01/01/2023 to 30/04/2023)	84.4%	89.2%	83.8%	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 (01/01/2023 to 30/04/2023)	92.2%	95.6%	93.0%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	64.6%	79.6%	71.3%	No statistical variation

Any additional evidence or comments

The practice was proactive in gaining feedback from their patients. They had a Friends and Family survey in place and the comments from the survey are reviewed. The majority of responses were positive about the care and treatment received along with comments about staff's professionalism and attitude.

The provider also used a Facebook page as a space for communicating with patients and feedback and had received a number of positive responses.

The practice had developed a GP Survey plan in response to indicators that have fallen below the national averages. For example, in response to 89% of patients who said they were involved as much as they wanted to be in decisions about their care and treatment, the practice had recognised a need to share decision-making and was incorporating this in regular medication reviews and medication management plans for the coming year.

	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Yes

Involvement in decisions about care and treatment

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

	Y/N/Partial
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

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023)	89.2%	93.6%	90.3%	No statistical variation

	Y/N/Partial
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 leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	371; 3%.
How the practice supported carers (including young carers).	Carers had appropriate health checks and support available for them.
How the practice supported recently bereaved patients.	Patients were send a card and a support leaflet. An alert was entered onto the electronic system and was left on the patient record for at least 3 months.

Privacy and dignity

The practice respected respect patients' privacy and dignity.

	Y/N/Partial
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

At our last inspection in May 2022, we rated this key question as requires improvement. At this inspection we rated this key question as good, as required improvements have been made.

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	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 in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

Practice Opening Times	
Day	Time
Opening times at the Royal Manor Health Care:	
Monday	8:30 am – 12:30 pm and 1:30 pm – 6:00 pm
Tuesday	8:30 am – 12:30 pm and 1:30 pm – 6:00 pm
Wednesday	8:30 am – 12:30 pm and 1:30 pm – 6:00 pm
Thursday	8:30 am – 6:00 pm
Friday	8:30 am – 6:00 pm
Appointments available at the Royal Manor Health Care:	
Monday	7:30 am – 12:30 pm and 1:30 pm – 6:00 pm
Tuesday	7:30 am – 12:30 pm and 1:30 pm – 6:00 pm
Wednesday	7:30 am – 12:30 pm and 1:30 pm – 6:00 pm
Thursday	8:30 am – 6:00 pm
Friday	8:30 am – 6:00 pm
Opening times and appointment available at the Gatehouse Surgery:	

Monday	8:30 am – 12:30 pm and 1:30 pm – 5:30 pm
Tuesday	8:30 am – 12:30 pm and 1:30 pm – 5:30 pm
Wednesday	8:30 am – 12:30 pm and 1:30 pm – 5:30 pm
Thursday	8:30 am – 12:30 pm and 1:30 pm – 5:30 pm
Friday	8:30 am – 12:30 pm and 1:30 pm – 5:30 pm

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional nurse appointments were available on Mondays, Tuesdays, and Wednesdays at 7:30 am for school-age children, so that they did not need to miss school, and for working-age patients.
- All parents or guardians calling with concerns about a child were offered a same-day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, those with a learning disability and offered registration for temporary patients.
- The practice offered home visits for house-bound patients and those who might need it.
- The practice had a separate phone line for patients with cancer and for their carers to access care and advice without delay.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- The practice had set up The Portland Leg Club, run by a group of volunteers, where patients registered with the practice with lower leg problem could attend every Thursday morning. The club provides leg ulcer management in a social environment which improved healing rates and patient's general wellbeing.
- The practice started a Lung Health pilot in December 2022, which focused on patients aged 55 – 74 who were smokers or ex-smokers to provide them with Targeted Lung Health Check specialist appointments.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes

Patients were able to make appointments in a way which met their needs.	Yes
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised.	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice offered early morning clinics 3 times a week on Mondays, Tuesdays and Wednesdays from 7:30 am. The practice was usually closed at lunchtime, but recently this has been changed and patients could access care and treatment at lunchtime every Thursday and Friday. The practice was also open for administrative queries at lunchtime 3 times a week.</p> <p>The practice was working closely with the PCN in their area and patients could access care and treatment at frequent Saturday clinics, where they could book for example, nurse appointments and first-contact physiotherapy.</p> <p>At the time of our inspection, waiting time for a routine appointment was between 3-4 weeks depending on the issue, but it has been evidenced this has gone down from 6 weeks wait in recent weeks.</p>	

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023)	49.7%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	40.9%	63.7%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	35.6%	60.9%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	69.1%	76.6%	72.0%	No statistical variation

Any additional evidence or comments

The practice had developed a GP Survey plan in response to indicators which had fallen below the national averages. For the indicator of only 35.6% of patients who were satisfied with their GP practice appointment

time, the provider had been working with the PCN to have more appointments available for patients. Some of the initiatives added in the last 12 months in the practice to improve access were:

- early morning clinics (from 7:30 am 3 times a week),
- Saturday clinics once a month (working towards providing this twice a month),
- Face-to-face and telephone GP appointments available on the day and at weekends,
- PCN appointments including: nurse appointments, spirometry and Dorset Mind appointments,
- 1-2 week wait appointment for those patient who don't need urgent appointment, but are unable to wait for more than 3 weeks,
- On day mental health worker appointments and physiotherapy appointments.

Source	Feedback
NHS.uk website (formerly NHS Choices)	There were 8 reviews available, 5 of which were in the last 12 months. The reviews were all 4 and 5 star rating out of 5. Positive feedback was seen regarding accessing urgent care, flu jab clinic and staff's professional approach and friendliness.

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	15
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Example(s) of learning from complaints.

Complaint	Specific action taken
Prescription not issued for patient when requested over the phone.	<ul style="list-style-type: none"> • Complaints process followed, including sending letter with apologies to the patient. • Issue investigated and additional training recognised for reception staff. • Learning shared with the team.

Well-led

Rating: Good

At our last inspection in May 2022, we rated this key question as requires improvement. At this inspection we rated this key question as good, as required improvements had been made.

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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: All staff reported to us that managers were available at both practices and there was an open-door policy with the practice manager. All staff were positive and complimentary about the support they have received from the practice management.	

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.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: The provider had developed their vision and values and presented them to us. All staff reported to us that they had been involved in creating the values and their input was valued. They felt listened to and included.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes

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

Source	Feedback
Interviews with staff	We received positive feedback from staff when conducting interviews, some comments included: <ul style="list-style-type: none">• “This is the best partnership I have ever worked for”.• “The practice works very efficiently, and I feel supported”.• “Management is very approachable and there is an open-door policy”

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.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes

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.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: The provider had developed a business continuity plan and introduced a programme of audits and action plans for issues and risks identified in the practice. For example, there was an action plan following poor responses to the national GP survey.	

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.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes

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.	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

Staff are supported to work remotely where applicable.	Yes
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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.	Yes
The practice had an active Patient Participation Group.	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
Explanation of any answers and additional evidence: The practice worked closely with both the PCN and Local Integrated Care Board (ICB) on a number of local quality improvement initiatives. For example, the practice was involved working with Island Community Action (meeting with them monthly and taking referrals for any vulnerable or frail patients) and with the Portland Foodbank.	

Feedback from Patient Participation Group.

Feedback
We spoke with a member of Patient Participation Group (PPG) and they were positive about the improvements in the practice and recognised work that's been put in since the last CQC inspection to expand access to care and treatment for the practice population.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: We saw improvement since the last inspection and the provider had learnt from it and made the required changes. For example, the provider improved and maintained governance systems and communication channels with staff. All staff felt included and encouraged to make input in decision-making where possible. There were regular practice meetings and the way information was disseminated to staff ensured everyone in the practice felt included.	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

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

Glossary of terms used in the data.

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