

# Care Quality Commission

## Inspection Evidence Table

### Heacham Group Practice (1-548173848)

Inspection date: 29 November 2022

Date of data download: 21 October 2022

## Overall rating: Requires improvement

Following our previous inspection on 8 March 2022, the practice was rated inadequate overall and for providing safe, effective and well-led services, requires improvement for providing responsive services and good for providing caring services. The practice was placed into special measures and issued with a warning notice relating to a breach of regulations. A subsequent focused review was carried out on 5 July 2022 where we found that the practice was partially compliant with the warning notice and a requirement notice was issued. This inspection on 29 November 2022 was a comprehensive inspection to follow up on the concerns identified during the inspection in March 2022.

At this inspection, we rated the practice as requires improvement overall.

## Safe

## Rating: Requires improvement

At the previous inspection on 8 March 2022, the practice was rated as inadequate for providing safe services because:

- The practice did not have oversight to ensure that staff had received appropriate training including safeguarding and infection prevention and control (IPC).
- There were significant gaps in the practice systems to assess, mitigate, monitor and manage risks to patient safety.
- The practice did not evidence that all medicines were prescribed safely to patients. We found concerns relating to the practice dispensary.
- The practice did not have a recruitment process in place which ensured staff had been recruited safely.
- The practice did not have an adequate system to learn and make improvements when things went wrong.

At this inspection, the practice was rated as requires improvement for providing safe services because:

- All staff had received appropriate training including safeguarding and IPC.
- The recruitment process in place ensured staff had been recruited safely.
- The practice had a system in place to learn and make improvements when things went wrong and the practice demonstrated an open culture to recognising errors, investigating and learning from these events.
- Whilst we saw that significant improvements had been made to ensure medicines were safely prescribed to patients, there were still further improvements required.
- The practice was responsive to any concerns and were proactive in correcting any issues.
- We found the dispensary was now being safely managed.

## Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y <sup>1</sup>
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y <sup>2</sup>
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 At the inspection in March 2022, the practice did not provide sufficient evidence to show that all staff had received appropriate safeguarding training. At this inspection, we saw that all staff members had received safeguarding training, appropriate to their job role. The practice had safeguarding policies in place for adults and children with named leads for each. There was also a safeguarding administrator in the practice. We found that there were some coding inconsistencies present in some patient records, where the safeguarding code had not yet been removed, or in one case, the code had been incorrectly added. The practice immediately rectified this and ran a search to ensure all patients had been correctly coded. They also introduced a new policy where the safeguarding administrator will regularly run this search.</p> <p>2 At our inspection in March 2022, the practice did not have clear oversight to provide evidence that all clinical staff had the appropriate DBS checks in place. At the review in July 2022 and at this inspection, we saw that all staff had an appropriate DBS certificate in place and the newly introduced practice policy, ensured that DBS checks were undertaken as part of the recruitment process and would be repeated each five years or sooner if the member of staff's role changed. We saw that the appropriate level of DBS checks had been obtained.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y <sup>1</sup>
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y <sup>2</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1 At the previous inspection in March 2022, we found that the practice system and process in place had failed to ensure all appropriate checks had been undertaken for all staff to ensure safe recruitment. At this inspection, we saw that the policy and process for recruiting staff had been updated and we saw that this was being followed. We saw that staff were now being recruited safely.</p> <p>2 At the previous inspection in March 2022, we found that whilst we saw some evidence of the immunisation status of clinical staff, this was not consistent for all clinical staff and the practice did not</p>	

have clear oversight of staff immunisation status to ensure the safety of patients and staff. At this inspection, we saw that the practice had clear oversight of the immunisation status of clinical staff which ensured the safety of patients and staff.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Various	P <sup>1</sup>
There was a fire procedure.	Y
Date of fire risk assessment: 31/05/2022 Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 At our inspection in March 2022, we found the practice system and approach to risk assessments did not ensure they were used effectively as a management tool to promote safety for staff and patients. We found risk assessments were not regularly monitored and issues identified had not always been actioned. At the review in July 2022, we found the practice had engaged external consultants to support their health and safety processes. Comprehensive risk assessments had been undertaken and the practice had a detailed action plan including the management of legionella. The practice had completed some significant refurbishments such as redecorating and new seating in the waiting area and a staff room had been upgraded. Staff we spoke with told us the improvements had made a significant difference to the environment.</p> <p>At this inspection, we found that the practice, whilst carrying out some water temperature checks, did not have complete assurance that they were following the correct process as the risk assessment which was provided by an external company was not clear and this had not been followed up. During the inspection, the practice contacted the external company to request further information to ensure they were following the correct protocol and that water temperature checks were being carried out at the correct intervals. The practice was awaiting a reply and told us they would adjust their process if necessary.</p>	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y <sup>1</sup>
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 03/11/2022 and 07/11/2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 At the previous inspection in March 2022, the practice did not have clear oversight of and did not provide sufficient evidence to show that all staff had received appropriate training for infection prevention and control (IPC). At this inspection, we saw that all required staff had received appropriate IPC training.</p>	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y <sup>1</sup>
There was an effective induction system for temporary staff tailored to their role.	Y <sup>2</sup>
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 At the previous inspection in March 2022, staff we spoke with told us they often worked short staffed and this had affected the safe and effective delivery of safe care and the well-being of staff. At this inspection, we were told that the practice had recruited more staff members so this had helped with the high workload at the practice.</p> <p>2 At the previous inspection in March 2022, staff we spoke with told us they had received a supported induction to the practice; however, the practice did not have a system to ensure this was fully documented. At this inspection, we saw that staff received a thorough, personalised induction plan which was signed as each stage was completed.</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.	P <sup>1</sup>
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y <sup>2</sup>
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y <sup>3</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1 During our previous inspection in March 2022, we reviewed some patient records and we found some inconsistencies in the quality of the record keeping. At the review in July 2022, we found the practice had made improvements and consultation records were detailed. However, due to the number of records that required review, this work was still in progress.</p>	

At this inspection, we looked at patient records and found that medicines reviews were being coded as completed, but not all medicines had been considered at all reviews. The practice informed us that after the inspection, they had spoken to staff who were completing these medicines reviews to ensure that patients had complete medicines reviews carried out by the correct clinician.

2 At the review in July 2022, the practice recognised that there had been shortfalls in the accurate coding and record keeping of patients' medical records. At this inspection, we saw that the practice now regularly audited coding to ensure it was being correctly used. However, we did identify some records which had been incorrectly coded for example where a safeguarding code had been incorrectly added to a patient record or not removed when required. The audit of coding was therefore not wholly effective.

3 At the previous inspection in March 2022, we found there was no backlog of test results and staff we spoke with told us GPs reviewed results for their own patients. At this inspection, we found that there was again, no backlog of test results and all were being managed in a timely manner. However, we found that there were 786 tasks which had not been marked as completed, the oldest of which was from July 2019. We saw, and the practice told us, that these tasks had been carried out but the tasks had not been marked as completed by the staff member. The practice told us that they were aware of this and were working to educate staff to ensure these tasks were closed when completed. An exercise was underway to ensure that the outstanding tasks were closed where appropriate.

## Appropriate and safe use of medicines

### The practice had made improvements to their 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 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)	1.08	0.92	0.82	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). (01/07/2021 to 30/06/2022) (NHSBSA)	10.7%	10.4%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	5.93	5.81	5.31	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	235.8‰	195.6‰	128.0‰	Tending towards variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) <small>(NHSBSA)</small>	0.58	0.96	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	10.0‰	12.2‰	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.	Y <sup>1</sup>
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y <sup>2</sup>
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	P <sup>3</sup>
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	P <sup>4</sup>
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y



Medicines management	Y/N/Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>1 At the previous inspection in March 2022, we saw that the dispensary was accessed by a keypad which was not limited to authorised staff only. At the review in July 2022 and at this inspection, the dispensary was secure and only authorised staff had the entry code which was regularly changed.</p> <p>2 At our previous inspection in March 2022, we found the practice did not evidence that they had monitored and assessed the competency of clinical staff who held a prescribing qualification. At the review in July 2022, we saw the practice had undertaken monitoring and formal discussions with staff. The previous inspection was carried out 17 weeks ago and therefore this work was still ongoing and not yet fully formalised. They told us further monitoring and education was in progress, for example, ensuring information from safety alerts was shared and monitored.</p> <p>At this inspection, we saw that these formal competency checks were being consistently carried out, with regular weekly meetings between clinical staff and a GP partner. These meetings were documented and had been received well by staff.</p> <p>3 During our previous inspection in March 2022, we reviewed some patient records and we found some inconsistencies in the quality of the record keeping. At the review in July 2022, we found the practice had made improvements and consultation records were detailed. However, due to the number of records that required review, this work was still in progress.</p> <p>At this inspection, we found that medicines reviews were being completed, but there were still some inconsistencies where not all medicines had been considered at all reviews. The practice informed us that after the inspection, they had spoken to staff who were completing these medicines reviews to ensure that patients had complete medicines reviews carried out by the correct clinician.</p> <p>4 As part of our inspection and with the consent of the practice we used a suite of clinical searches on the practice system. Following these searches, we reviewed some patient records. At the inspection in March 2022, we found the process for monitoring patients' health in relation to medicines was inadequate. At this inspection we saw that significant improvements had been made including a staff member being responsible for running clinical searches to ensure patients had the appropriate monitoring in place.</p> <p>Our clinical searches identified 56 patients prescribed methotrexate (a medicine to treat autoimmune conditions) and 3 of these patients appeared to not have had the appropriate monitoring. Of these 3 patients, 1 had been contacted recently requesting the patient attend the practice for monitoring, 1 had blood test results on the computer system already and the last patient was not taking the medicine. All of these patients had therefore been appropriately managed.</p> <p>We saw that 337 patients were being prescribed direct oral anticoagulant drugs (DOAC's) and all these patients had been appropriately monitored.</p> <p>We saw that all patients who were prescribed a medicine which can cause birth defects if taken during pregnancy had been appropriately managed.</p>	

Medicines management	Y/N/Partial
We saw that 3 patients had a potential missed diagnosis of diabetes and all these patients were being appropriately managed by the practice.	
We saw that 76 patients had been prescribed more than 10 prescriptions for benzodiazepines or Z drugs (medicines to help anxiety or insomnia). We looked at 5 patient records and, in all cases, found that these medicines had not been prescribed at the required quantities and this had not been identified by the practice when represcribed or during a medicines review. After the inspection, the practice told us they had contacted these patients and requested a medicines review appointment as soon as possible. They also limited the repeat prescribing of these medicines to 1 month, to ensure the patient was reviewed before issuing another repeat prescription. The practice also told us that they had now set up an additional search so that any patient who had received more than 3 prescriptions for these medicines in any month would be identified and a GP tasked with reviewing the patient.	
We saw that 72 patients with asthma had been prescribed 2 or more courses of rescue steroids. We looked at 5 patients records and saw that 4 had been appropriately managed. The practice told us that the last patient had now been invited to a face to face appointment to discuss their medicines.	
We saw that all patients registered at the practice with chronic kidney disease (CKD) stages 4 or 5 had been appropriately managed.	
We saw that our initial search indicated that there were 3 patients taking a medicine for an underactive thyroid gland who had not had appropriately monitored. We looked at these 3 patient records and found that all 3 had been appropriately managed.	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
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.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y <sup>1</sup>
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.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
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.	Y
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Y <sup>2</sup>



Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y <sup>3</sup>
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>Explanation of any answers and other comments on dispensary services:</p> <p>1 At the inspection in March 2022, the practice had not undertaken competency checks with the dispensary staff that worked in the practice. At this inspection, the dispensary staff told us that they had completed and documented competency checks by the named GP lead for the dispensary.</p> <p>2 At the inspection in March 2022, we saw that the practice offered a delivery service to their patients who were housebound but the practice had not fully and comprehensively risk assessed this. At this inspection, we saw that the delivery service had a full risk assessment and the process had been improved to include a patient signature on delivery of high risk medicines.</p> <p>3 At the last inspection in March 2022, the practice failed to demonstrate a safe and effective system for the identification, reporting, investigating and actions and learning outcomes for any incidents that may have occurred within the dispensary. At this inspection, we saw that all staff were aware of how to report a significant event or incident, these were discussed at meetings and learning was shared. We saw that the system and process for reporting, investigating and learning from these events had been improved and the practice had implemented a no-blame culture.</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.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	60
Number of events that required action:	60
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in March 2022, we found the practice system to monitor and review safety was inadequate. The practice did not have a consistent approach or documentation for staff to report incidents, however minor.</p> <p>At the review in July 2022 and at this inspection, we saw the practice had addressed this issue. The practice had reviewed previous events and ensured they had been addressed. With the support of the external Integrated Care Board (ICB), the practice had undertaken staff meetings to encourage and engage staff in an open culture of reporting events, however minor. The staff we spoke with told us this had been very successful, staff had given positive feedback on the engagement and learning from events as a whole practice team. The practice had introduced an electronic reporting system to ensure all events were recorded and managed appropriately. Although these events identified had been serious, we did not see that any patient had been harmed. The practice had complied with the duty of candour and involved the patients as appropriate in any investigations, discussions and outcomes.</p>	

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

Event	Specific action taken
An external clinical team sent an urgent task directly to a GP. This task was not seen by the GP and therefore not actioned. When this was identified by the reception team, the patient was immediately offered a face to face appointment that day but there had been a delay.	The practice contacted the external clinical team and reiterated that the process is for the team to ring the practice for an urgent task, to ensure all patients are appropriately managed and followed up.
A delay in a GP reading a letter from a hospital regarding a patient.	The GP had a backlog of letters, it was reiterated that practice policy is that all letters are read within 3 days of being received. The backlog was cleared by the GP and this was also discussed in the next clinical governance meeting.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in March 2022, the practice had implemented a new system to manage safety alerts. However, we found that it had not been fully implemented and embedded.</p> <p>At the review in July 2022 and at this inspection, we found the practice had improved their system to action alerts and had set up processes to monitor them. They had also reviewed previous alerts to ensure their searches incorporated all the correct information. From the clinical searches we carried out, we saw that these were being managed effectively.</p>	

## Effective

## Rating: Requires improvement

At the last inspection in March 2022, the practice was rated inadequate for providing effective services because:

- Patients' needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance.
- During the COVID-19 pandemic, the practice had paused some long-term conditions clinics. They recognised there was a backlog of annual checks for patients. The practice had developed an action plan to address this issue. We found as part of this inspection, some patients on long term medicines had not been monitored or reviewed appropriately.
- The practice was unable to demonstrate that staff had all the skills, knowledge and experience to carry out their roles.
- There was limited monitoring of the outcomes of care and treatment. The practice did not have a programme of quality and improvement to monitor and ensure care was delivered in a safe and effective way.

At this inspection, the practice is rated as requires improvement for providing effective services because:

- The practice had implemented a process to reintroduce NHS health checks in the practice, trained staff to carry out these checks and bought equipment to increase the efficiency.
- Although the practice had made improvements, we found that not all patients' needs were fully assessed. Care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance.
- The practice was able to demonstrate that staff had all the skills, knowledge and experience to carry out their roles.
- There was a programme of quality and improvement to monitor and ensure care was delivered in a safe and effective way.

*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 fully assessed. Care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y <sup>1</sup>
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y

Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	P <sup>2</sup>
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 At the previous inspection in March 2022, we did not see evidence that learning was embedded, shared and monitored. At this inspection, we saw that learning was shared at regular practice meetings and also between team members at team meetings. We saw that regular supervisions were taking place which also facilitated and encouraged shared learning.</p> <p>2 At the inspection in March 2022, we found the practice had not always undertaken comprehensive medicines reviews. We found the information in the records lacked sufficient detail to be assured all medicines had been assessed and the patients' ongoing needs had been managed safely.</p> <p>At this inspection, we found that medicines reviews were being completed, but there were still some inconsistencies where not all medicines were being considered at all reviews. The practice informed us that after the inspection, they had spoken to staff who were completing these medicines reviews to ensure that patients had complete medicines reviews carried out by the correct clinician.</p>	

## Effective care for the practice population

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- NHS health checks were previously being carried out by a local pharmacy. The practice told us that 559 patients had previously been offered a health check, yet uptake was poor with only 5 being carried out. However, the practice planned to provide health assessments and checks including NHS checks for patients aged 40 to 74 directly at the practice from December 2022. The practice had trained 2 nurses to provide these health checks and a healthcare assistant was also being trained to support these. The practice recently purchased a cholesterol testing machine so that patients receive a result of their blood cholesterol level all at the same appointment, avoiding the need to return. The practice told us that appointments will be offered during extended hours to increase the number of available appointments for these health checks. 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. The practice told us there were 35 patients registered at the practice with a learning disability and 33 of these patients had had their annual health check. There was a named clinician who was responsible for carrying out these health checks which helped with continuity of care.
- 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 a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs where appropriate.
- Patients with asthma were offered an asthma management plan.
- As part of our inspection and with the consent of the practice we used a suite of clinical searches on the practice system. Following these searches, we reviewed some patient records. We saw that there were 58 patients with diabetic retinopathy with the latest HbA1c of >74mmol/l. We looked at 5 patient records and found that all patients had been managed appropriately with respect to their diabetes and all patients had received an annual diabetic review with an appropriate clinician. We did see that for 2 patients, the medicines review had not been fully completed. The practice informed us that these patients will be reviewed.
- The practice had a designated nurse lead for diabetes who was supported by a specific HCA.

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)	34	36	94.4%	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)	48	50	96.0%	Met 95% WHO based target

(01/04/2020 to 31/03/2021) (NHS England and Improvement)				
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)	48	50	96.0%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	48	50	96.0%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	46	50	92.0%	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 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)	73.6%	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)	80.4%	70.2%	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)	71.4%	70.4%	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)	47.9%	53.8%	55.4%	No statistical variation

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.

Any additional evidence or comments
The practice recognised their performance for cervical screening was lower than the 80% target. Staff we spoke with told us they were offering appointments to patients at various times. This enabled patients to



attend the practice at times that were convenient to them. The practice told us that they were considering offering appointments during extended hours for cervical screening.

## Monitoring care and treatment

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

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

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

At our previous inspection in March 2022, the practice did not evidence that clinical audits were being used.
At this inspection, we were shown multiple clinical audits which the practice had carried out. We were also told that the practice had an audit calendar to ensure these are carried out on a regular basis.
<ul style="list-style-type: none"> <li>The practice completed an audit looking at patients' preferred choices about care at the end of their lives (ReSPECT/ DNA-CPR) in November 2022. This audit was undertaken to check for correct coding of ReSPECT/ DNA-CPR consultations for these forms, when they were written/ loaded to system and if there was any need to review them due to change in condition or setting in which they were written. Actions were taken to address any issues identified and the practice will be running a further cycle in February 2023.</li> <li>A chronic kidney disease audit was completed March 2022 and thereafter on a 3 monthly basis. This audit was undertaken to ensure that all patients with a GFR of less than 60 on 2 occasions over a 3-month period had a code of CKD in their notes. The audit was repeated in July 2022 and October 2022 which showed improvements. The audit will be re-run in January 2023.</li> </ul>

## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y <sup>1</sup>
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y <sup>2</sup>

Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y <sup>3</sup>
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 At the inspection in March 2022, the practice failed to clearly evidence they had oversight of the skills, knowledge and experience of their staff. Prior to our inspection, the practice had, as part of the development plan, identified that most staff required to undertake a range of training that they deemed mandatory including safeguarding and basic life support. Staff had been asked to complete this training and we were told some staff had, either in protected time or in their own time, however, the practice had not collated the information to show which staff had completed their training.</p> <p>At this inspection, we saw that the practice was using a new computer system to record and monitor staff training. All staff members were up to date with mandatory training. Additionally, clinical staff were receiving regular supervisions with a GP to ensure a high standard of patient care.</p> <p>2 At the previous inspection in March 2022, staff we spoke with told us they had received a supported induction to the practice; however, the practice did not have a system to ensure this was fully documented. At this inspection, we saw that staff received a personalised induction plan which was fully documented and signed as each stage was completed.</p> <p>3 Clinical staff, for example the dedicated lead for diabetes, told us that they had regular planned weekly supervisions with a GP in the practice to discuss patients they had treated and any concerns or queries. These supervision sessions were fully documented. Additionally, we were told that proactive supervised sessions were in place where GP's met with advanced nurse practitioners, who in turn met with nurses, who in turn met with healthcare assistants.</p>	

## Coordinating care and treatment

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

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

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y

Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y <sup>1</sup>
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 At the previous inspection in March 2022, we saw that some health checks had been paused during the COVID-19 pandemic, such as NHS health checks. As part of their recovery plan, the practice intended to reinstate these. Some of these checks were carried out by the local pharmacy. The practice told us that 559 patients had been offered a health check, yet uptake was poor with only 5 being carried out.</p> <p>At this inspection, we were told that the practice will be providing these health assessments and checks including NHS checks for patients aged 40 to 74 directly at the practice from the start of December 2022. The practice had 2 trained nurses who will provide these health checks and a healthcare assistant is also being trained to carry these out. The practice recently purchased a cholesterol testing machine so that patients received a result to their blood cholesterol level all at the same appointment, avoiding the need to return. The practice told us that appointments will be offered during extended hours to increase the number of available appointments for these health checks.</p>	

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence</p> <p>The practice had recently completed an audit on DNACPR/Respect forms. This showed that the use of DNACPR forms instead of Respect forms was common, and 10 patients would benefit from a review of their wishes as the form was signed over 1 year prior. All actions were carried out and the practice aims to run another audit cycle in February 2023.</p>	

## Caring

## Rating: Good

Caring remains rated as Good.

### 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.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

Patient feedback	
Source	Feedback
Healthwatch Norfolk	In July 2022 Healthwatch Norfolk visited the practice to speak to patients about their experience with the practice. They received 35 reviews for the practice. The reviews had an average star rating of 3.4 (out of five). Positive feedback was regarding caring and kind staff and negative feedback was regarding difficulty accessing appointments.
NHS Website	We reviewed all the reviews on the NHS website (6 reviews left from May 2022 until August 2022). There were 2 comments rating the practice 5 star reviews regarding kind and efficient staff, 1 comment rating the practice 3 star review commenting on a delay in receiving an appointment, 1 comment rating the practice 2 star review regarding a wait to see a GP, and 2 comments rating the practice 1 star reviews regarding poor communication and poor access to appointments. The practice had responded to 1 of these comments.
Care home representatives	We spoke to care homes where the practice cared for residents. We received positive feedback from them regarding kind and caring staff. We did receive some feedback that prescriptions can sometimes be delayed, but this had not resulted in any harm to patients.
Compliments	We saw multiple compliments which the practice had received. These commented on the caring nature of all staff, from clinicians to reception staff. These were shared between staff members in the practice.

## 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 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)	83.0%		86.4%	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)	76.6%		85.8%	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)	91.3%		94.5%	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)	62.8%		75.7%	72.4%	No statistical variation

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

Any additional evidence
The practice carried out a patient satisfaction survey in September 2022. The practice received 126 responses of which the majority were positive and compared favourably to national and local data. The practice acted upon feedback, for example the telephone system is in the process of being upgraded as some patients commented about this. Additionally, some feedback requested more face to face appointments which the practice now offer.

## 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.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

Source	Feedback
Feedback from patients.	Feedback we received from patients included complaints regarding a lack of face to face appointments and one comment regarding an abrupt manner from a clinician.

## 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 average	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 (01/01/2022 to 30/04/2022)	79.5%	92.0%	89.9%	Tending towards variation (negative)

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y <sup>1</sup>
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: 1 The practice had made the decision not to have any leaflets available in the waiting areas due to increased cross infection control measures in place, but were able to print, email or text relevant information to patients as needed. Additionally, notice boards were used to display up to date and relevant information to patients, such as information for carers and available support groups.	

Carers	Narrative
Percentage and number of carers identified.	164 registered carers, 2.1% of the total list size



How the practice supported carers (including young carers).	The practice had information on their website for carers with links to multiple carers groups including Carers UK and Carers Matter Norfolk.
How the practice supported recently bereaved patients.	The practice told us that they scheduled a telephone call with relatives to offer condolences and also to ensure that they offer medical support where required. They considered referring to the social prescribing team if required and they had also begun sending a sympathy card to relatives. The practice website also contained information for recently bereaved patients.

## Privacy and dignity

### The practice respected patients' privacy and dignity.

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

## Responsive

## Rating: Requires improvement

At the last inspection in March 2022, we rated the practice as requires improvement for providing responsive services because

- Complaints were not used to improve the quality of care. We could not be assured all complaints the practice had received had been reviewed, investigated and actions taken. The practice failed to evidence that patients who may have been affected had received an apology and explanation.
- The practice had, following the lifting of restrictions relating to the COVID-19 pandemic, amended their appointment system and now offered patients a choice of face to face or telephone appointments. We noted, the GP patients survey data 2021 showed a decline in patient satisfaction from 2019 and 2020.

At this inspection, we rated the practice as requires improvement for providing responsive services because:

- The GP patient survey data 2022 showed a decline in patient satisfaction from 2021.
- Whilst the process for dealing with complaints had been improved, time was needed to ensure these improvements had been embedded.

### 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.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	

Practice Opening Times	
Day	Time
Opening times:	
Monday	08:30-18:30
Tuesday	08:30-18:30
Wednesday	08:30-18:30
Thursday	08:30-18:30
Friday	08:30-18:30
Appointments available:	
Monday	08:30-18:30

Tuesday	08:30-18:30
Wednesday	08:30-18:30
Thursday	08:30-18:30
Friday	08:30-18:30

#### 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.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- 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, and those with a learning disability.
- 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.

#### 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 minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
Explanation of any answers and additional evidence: The practice told us that as a result of staff and patient feedback, they had increased the number of reception staff and also increased the number of face-to-face appointments available to patients.	

## 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 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)	41.4%	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)	52.3%	61.7%	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)	51.2%	59.8%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	67.3%	77.0%	71.9%	No statistical variation

## Any additional evidence or comments

The National GP Patient Survey data showed that whilst there is no statistical variation in the data, satisfaction levels amongst patients had decreased in all of the areas. For example;

- 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 had decreased from 57% in 2021 to 41.4% in 2022.
- The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment had decreased from 57% in 2021 to 52.3% in 2022.
- The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times had decreased from 65.1% in 2021 to 51.2% in 2022.
- The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered had decreased from 75.5% in 2021 to 67.3% in 2022.

The practice was aware of this decrease in satisfaction and was disappointed with the feedback. As changes the practice had implemented had been recently made, there had not been time for this to be reflected in the GP patient survey results. For example, additional reception staff had been recruited to allow for a shorter waiting time on the telephone and improve access to making appointments, the number of face-to-face appointments offered had been increased and with the help of the ICB, the telephone system was in the process of being upgraded.

Source	Feedback
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NHS Website	We reviewed all the reviews on the NHS website (6 reviews left from May 2022 until August 2022). There were 2 comments rating the practice 5 star reviews regarding kind and efficient staff, 1 comment rating the practice 3 star review commenting on a delay in receiving an appointment, 1 comment rating the practice 2 star review regarding a wait to see a GP, and 2 comments rating the practice 1 star reviews regarding poor communication and poor access to appointments. The practice had responded to 1 of these comments.
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## 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.	24
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in March 2022, we found the practice system to monitor and review complaints was inadequate. The practice did not have a consistent approach or documentation for staff to report complaints or feedback. The details of any investigation, discussion, actions and learning outcomes were not documented in a way that would allow a full and complete review, shared learning or monitoring.</p> <p>At this inspection, we found the practice system to monitor and review complaints had been improved and work was ongoing to implement further improvements. We saw that complaints were fully documented and discussed, with evidence of learning shared in the practice. The practice told us that they had recently completed an audit on complaints which had identified some shortfalls. Changes had been implemented, but time was needed to ensure these were embedded and resulted in positive change. For example, complaints had been verbally acknowledged within the practice's timescale, but as a result of the audit, this had been changed to include a written acknowledgement in addition to verbal acknowledgment. We also saw that even when a complaint was submitted and then withdrawn, the practice still completed an investigation which resulted in shared learning for the team.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient had been referred to a different service than the patient expected.	Apologised to the patient and the GPs made aware to clearly specify the service for the referral.

## Well-led

## Rating: Requires improvement

At the previous inspection of March 2022, we rated the practice as inadequate for providing well-led services because:

- The practice failed to demonstrate they provide safe and effective care to patients.
- During our inspection we found practice leaders could not fully demonstrate that they had the capacity and skills to deliver high quality sustainable care.
- The practice did not have a clear vision and or strategy to provide high quality sustainable care.
- The practice culture did not effectively support high quality sustainable care.
- The overall governance arrangements were ineffective.
- The practice did not have clear and effective processes for managing risks, issues and performance.
- The practice did not always act on appropriate and accurate information.

At this inspection, we rated the practice as requires improvement for providing well-led services because:

- Following our inspection on March 2022, the practice had improved their leadership. They told us they had reflected on the findings of the previous report. They told us they achieved this by working cohesively as a management team and communicating with staff.
- The practice had accepted support from the Integrated Care Board and an external team to undertake a quality improvement programme and make the required improvements.
- We found that practice leaders demonstrated that they had the capacity and skills to deliver high quality sustainable care.
- The practice had a clear vision and strategy to provide high quality sustainable care.
- Whilst we saw improvements in the overall governance arrangements, there were still some areas where the practice did not have complete oversight. For example in respect of medicines management, the legionella risk assessment, complaints management and some audits had not been wholly effective.
- The practice had some clear and effective processes for managing risks, issues and performance.
- The practice acted upon appropriate and accurate information.
- These improvements had been newly established and required further time to be fully implemented, embedded and monitored to ensure improvements would be sustained.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: Since the inspection in March 2022 and from feedback, leaders in the practice recognised that additional staff were required to deal with the high workload and hence new staff had been recruited. Staff reported	



to us that leaders were now much more visible in the practice and GP partners attended other team meetings which was beneficial for all staff members.

## Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: At the previous inspection in March 2022, staff told us that they had not been involved in the development of the vision and strategy. At this inspection, staff members told us that they were aware of the practice's vision and had clear roles and responsibilities to help achieve these.	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: At the previous inspection in March 2022, the practice culture did not effectively support high quality sustainable care. At this inspection, we found that staff felt happy to raise a concern and the process for reporting significant events and complaints had been improved with a no-blame culture. Staff felt supported by all leaders. We saw evidence of compliance with the duty of candour and all staff had completed equality and diversity training.	

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

Source	Feedback
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Staff questionnaires	We received feedback from 8 staff members. Staff commented on the good team work in the practice and that they felt respected by leaders. Staff said that the improvements carried out in the practice since the last inspection had been very welcome and positive, with the management team now being more approachable.
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## Governance arrangements

**There were some 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.	P <sup>1</sup>
Staff were clear about their roles and responsibilities.	Y <sup>2</sup>
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y <sup>3</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1 At the previous inspection in March 2022, the governance structure had failed resulting in significant concerns.</p> <p>At this inspection, we found that the governance structures and systems in the practice had been reviewed and strengthened with the help of the local Integrated Care Board (ICB) and an external team. However, whilst we saw some improvements, there were still some areas where the practice did not have complete oversight. For example in respect of medicines management, the legionella risk assessment, complaints management and some audits had not been wholly effective.</p> <p>2 At the previous inspection in March 2022, we found that there were not clear roles and responsibilities within the partnership and leadership team. At this inspection, we found that staff had and were aware of their clear roles and responsibilities.</p> <p>3 Whilst there were currently no backlogs of activity which needed to be managed, the practice had a system in place should this occur which included the recent recruitment of additional staff to carry out this work.</p>	

## Managing risks, issues and performance

**There were some processes in place for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	P <sup>1</sup>
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y

When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 At the previous inspection in March 2022, we found that there were significant shortfalls in the leadership and management leading to significant concerns in good governance, safe and effective prescribing, ensuring staff had received appropriate training and were competent to undertake their roles.</p> <p>At this inspection, we found that leadership and management in the practice had been strengthened with the help of the ICB and an external team. We saw that a new training system had been implemented and staff had received appropriate training and also had regular documented competency checks and supervisions. The practice had implemented new policies to ensure that prescribing was safe and effective. However, we did find that despite a coding audit being regularly carried out, there were some errors in coding of patient records, for example with a safeguarding code and additionally where some patients had been coded as having had a medicines review but they had not had a complete review. This demonstrated that the audit had not been wholly effective.</p> <p>We also saw that the practice, whilst carrying out some water checks, did not have complete assurance that they were following the correct process as the legionella risk assessment which was provided by an external company was not clear and this had not been followed up. During the inspection, the practice contacted the external company to request further information to ensure they were following the correct protocol and that water temperature checks were being carried out at the correct intervals. The practice were awaiting a reply. This demonstrated that the practice did not have complete oversight of the legionella risk, despite a risk assessment having been carried out.</p>	

### Appropriate and accurate information

#### There was a demonstrated commitment to using data and information proactively to drive and support decision.

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in March 2022, we identified areas of poor information recording and a lack of quality and improvement systems such as clinical audit.</p> <p>At this inspection, we saw multiple clinical audits had been carried out which had resulted in improvements in process and patient care. For example an audit was carried out regarding patients taking a medicine for diabetes who are at a higher risk of vitamin B12 deficiency. This audit resulted in a positive change to practice policy and process whereby all patients taking this medicine will now be assessed for B12 deficiency at every annual review.</p>	

### Governance and oversight of remote services

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

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

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y <sup>1</sup>
The practice had an active Patient Participation Group.	Y <sup>2</sup>
Staff views were reflected in the planning and delivery of services.	Y <sup>3</sup>
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1 We saw evidence of changes which had been made as a result of patient feedback, for example installing a new telephone system to improve the waiting process.</p> <p>2 At the previous inspection in March 2022, we were told that there was not an active Patient Participation Group (PPG).</p> <p>At this inspection, we were told that the PPG had recently restarted meeting and it had a new chairperson who was appointed in July 2022. They held an open meeting in September 2022 which was attended by over 100 people. We were told that a GP partner and the practice manager regularly attend meetings. Areas on which the PPG wished to focus in the future included access and communication. The restart of the PPG with regular meetings had been positively received by the practice and the local population.</p> <p>3 Staff we spoke with told us that at regular staff meetings, changes were discussed and they felt comfortable raising concerns.</p>	

### Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<b>Explanation of any answers and additional evidence:</b> At the last inspection, the practice failed to evidence that there was a focus on continuous learning and improvement. At this inspection, the practice showed us that the systems and processes in place had been changed and improved to ensure continuous learning. For example, regular team meetings were attended by GPs so information and learning was passed between teams. We also saw minutes from meetings where learning from events was shared.	

#### Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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

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