

## Inspection Evidence Table

### Crawley Road Medical Centre

(1-546109592)

**Inspection Date: 3 and 9 May 2023**

Date of data download: 02/05/2023

### Overall rating:

### Requires Improvement

At our last announced inspection of this provider on 30 June 2022, we rated the provider as inadequate overall as we found that the provision of service by the provider in relation to safe, effective, caring, responsive and well-led services did not meet the requirements of the Health and Social Care Act (HSCA) Regulated Activities (RA) 2014. At this time key questions safe, effective, caring and well-led were rated as inadequate and key question responsive was rated as requires improvement.

At this inspection dated 3 and 9 May 2023, we found that that the provider had made improvements in the key questions previously rated inadequate. While the provider had made improvements (in most of the previously identified issues), we found some areas of the service still required further work to be completed to achieve consistency in the delivery of services.

Based on our overall findings in which we recognise the impact of improvements in governance, in delivery of care for patients at the practice, and the likely sustainability of these improvements due to changes in personnel and in the approach to the delivery of patient care, the practice is now rated requires improvement overall.

# Safe

## Rating: Requires Improvement

*At our last announced inspection of this provider on 30 June 2022, we rated the provider as inadequate for the provision of safe services as we found the practice did not have adequate safety systems and/or processes in place. This was evidenced through the lack of processes relating to safeguarding and recruitment, lack of induction programme for new or locum staff, lack of action on information to assist delivery safe care and treatment, no risk assessments relating to fire and health and safety, and lack of management relating to safety alerts and significant events.*

*At this inspection held on 3 and 9 May 2023, we found that the practice had resolved most issues identified during the June 2022 inspection. The practice now had an effective system to ensure the management of test results received, recruitment records and reviewing and actioning safety alerts. Risk assessments had been completed by external contractors for fire and health and safety. Staff had access to information to help them deliver safe care, but we had some concerns relating to reception staff being equipped to respond to medical emergencies, in particular suspected sepsis. We also had concerns relating to the practice medicines management relating to implementing timely changes to a patient's medicines made by other services.*

*As a result of the improvements made by the practice as identified at our recent inspection, the practice is now rated as requires improvement for the provision of safe care.*

### **Safety systems and processes**

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

<b>Safeguarding</b>	<b>Y/N/Partial</b>
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y

There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	P
<p>Explanation of any answers and additional evidence:</p> <p>The provider had put in place systems and processes with regards to safeguarding and management of patient registers. We viewed the safeguarding register (which had been established following our July 2022 inspection) and found that records on the register were correctly placed there and had been coded accordingly. When asked, individual members of staff were able to tell us who was the lead for safeguarding and tell us what they would do if they witnessed an event that they considered as a safeguarding concern. In addition, staff told us contact would be made with relevant external stakeholders such as local social services to inform them of concerns. Administrative staff told us that they were trained to either safeguarding levels one or two. We viewed the training record for one member of administrative staff which aligned with what we were told regarding their level of safeguarding training. The senior GP partner at the service was the safeguarding lead and their training record showed they were trained to safeguarding level three as required.</p> <p>There was a combined safeguarding policy for adults and children, which were kept on the internal shared computer drive used in the practice. The clinical system used at the practice allowed for coding of records to indicate if a patient was vulnerable, alerting staff to this when that patient record was accessed.</p> <p>We looked at four staff files and found all but one staff member had a DBS check on their staff file. We spoke with the provider about this, and they told us that the DBS check was currently being processed and that this member of staff did not have contact with patients.</p> <p>The practice could discuss with the inspection team a recent referral that had been made to the local Multi Agency Safeguarding Hub (MASH). However, we were not shown the referral on the clinical system.</p>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	P
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	P
<p>Explanation of any answers and additional evidence:</p> <p>Prior to the last full comprehensive inspection, the Commission received concerns around recruitment processes within the practice. At that time, the practice told us there was a high turnover of staff and ongoing recruitment was taking place.</p>	

At this inspection we found that staff recruitment had continued but that the number of staff leaving the practice had subsided, but recruitment was still ongoing to fill existing vacancies.

Of the four staff files we viewed, we found that there were gaps in all files. These gaps ranged from gaps in details relating to training to missing proof of identity.

One staff file we viewed did not have details of immunisations received. We noted that this member of staff was a clinical member of staff who had recently started working at the practice.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: 30 September 2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: 30 September 2022	Y
Actions from fire risk assessment were identified and completed.	P
<p>Explanation of any answers and additional evidence:</p> <p>We viewed the most recent internal health and safety risk assessment which was undertaken in September 2022. The practice's fire risk assessment (which was undertaken by an external provider) was also completed in September 2022. We noted that there were some outstanding actions requiring completion on the assessment.</p> <p>We spoke with the provider about these and were told that these were in progress but that there was discussion with the external company who had undertaken the assessment regarding some disputed areas of the assessment. We were not told when the report had been received by the practice following the September 2022 assessment and how long the discussions had been taking place.</p> <p>The practice had a fire policy in place which specified the trained fire wardens within the practice.</p>	

**Infection prevention and control**

**Appropriate standards of cleanliness and hygiene were partially met.**

	Y/N/Partial
Staff had received effective training on infection prevention and control.	N
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: April 2023	Y
The practice had acted on any issues identified in infection prevention and control audits.	P
The arrangements for managing waste and clinical specimens kept people safe.	N
<p>Explanation of any answers and additional evidence:</p> <p>The provider provided the inspection team with a staff matrix which recorded what training had been undertaken by each member of staff. We noted four members of staff did not have infection control training recorded within the matrix.</p> <p>We viewed the most recent infection control audit and found that not all questions on the audit had been answered in full. We noted on the audit that the provider had not addressed an issue relating to the management of cleaning mops held at the practice to assure themselves that mops used for cleaning were cleaned daily, changed weekly and stored correctly to prevent the possible spread of infection.</p> <p>A visual inspection of the practice premises noted that patient areas were clean. However, we noted that the décor of the practice required updating and attention needed to be paid to the cleaning and maintenance of the staff toilet area.</p> <p>There was a system for the disposal of clinical waste, however when we checked the area where the clinical waste was stored (externally), we found that the bin was not the appropriate external bin for storage of clinical waste and the bin was not secured by a lock, which meant it could be accessed by persons not working at the practice.</p>	

**Risks to patients**

**There were gaps in 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.	P

There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	P
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.	N
There were enough staff to provide appointments and prevent staff from working excessive hours.	P
<p>Explanation of any answers and additional evidence:</p> <p>At our June 2022 inspection, we were not assured that the GP partners spent sufficient time onsite to ensure there was adequate clinical oversight. In addition, one of the GP partners was the sole provider of GP services at a neighbouring practice. At this inspection, whilst there was a level of assurance that the GP partners were onsite more to monitor and undertake clinical activity, there was a lack of assurance that the partners worked together at practice. We saw evidence of monitoring by one of the GP partners (via copies of emails) of clinical pharmacists. The monitoring included discussions of checks (by the GP partner) of completed patient notes following a consultation with the clinical pharmacist.</p> <p>The approach to managing staff absences and busy periods had improved since our last full comprehensive inspection. The provider has employed a new practice manager, who had been working alongside the practice partners to ensure that the practice had sufficient staff to run the services effectively. The practice had employed several new reception staff, some of whom are still in their induction period. There was a written induction programme for temporary or newly appointed staff and a knowledge check related to learning was given to new staff to complete. The knowledge check was reviewed by the practice manager, for them to identify any areas where further knowledge would be beneficial for new staff.</p> <p>This provider had addressed outstanding patient documents issue which we identified as having an effect on patient care at our inspection in June 2022. Four new members of staff had been taken on to review/summarise outstanding patient documentation. Existing administrative staff had been given timescales to ensure that patient correspondence was actioned in a timely manner.</p> <p>Not all reception staff we spoke with were aware of actions to take when they encountered patients who were very unwell. We spoke to receptionists on the day of the site visit about what signs/symptoms they would associate with a patient presenting with Sepsis. None of the answers that the inspection team received correlated with the known symptoms of Sepsis. It was noted that the area where receptionists sat had a poster which documented symptoms associated with possible Sepsis. We spoke to the GP partners and the practice manager about this matter and was told that all staff members will be required to refresh their training on sepsis.</p> <p>Staff we spoke with on the day of inspection told us that cover for colleagues for both planned and unplanned absences was available when needed. We did note that the new practice manager was working</p>	

increased hours to ensure that new policies and systems put in place at the practice were embedded appropriately.

**Information to deliver safe care and treatment**

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	P
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	P
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.	P
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Management of patient records had improved since our June 2022 inspection. Care records we viewed were now written in line with General Medical Council guidance on keeping clear and accurate records. Patient records viewed on the day of inspection had been completed to a satisfactory standard.</p> <p>There was a system in place for processing information relating to new patients including the summarising of new patient notes, but this was yet to be implemented as of the date of the site visit. The summarising was to be completed by medical personnel who had not yet been trained on the practice clinical system to summarise patient records. We identified on the day of our site visit that 2252 patient records had not been summarised. As part of our review of clinical records, we noted that there was appropriate management of test results (by appropriately qualified staff) when received at the practice.</p> <p>There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment at the practice. The GP partners were able to talk with the inspection team about a recent multi agency safeguarding hub (MASH) referral they had done. We saw (through copies of meeting minutes) that information relating to the patients of concern were discussed at practice meetings. The inspection team requested copies of meeting minutes that the practice held with other healthcare providers</p>	

(in relation to the provision of care of patients registered at the practice), to evidence that these meeting took place, but we were not provided with this information.

We were told that there was a system to managing test results and when we viewed the practice clinical system, we could see that laboratory results were assigned to specific members of staff to action, but we were not told to what timescale staff were expected to process these results.

We noted in the evidence provided by the provider as part of the inspection, that timely delivery of care and treatment to patients did not always occur if information from secondary care was received at the practice. The practice had identified several occasions (recorded as significant events) where the practice did not action requests from secondary care to change a patient's medication dosage once the request had arrived at the practice.

### 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) (01/01/2022 to 31/12/2022) (NHSBSA)	0.26	0.65	0.86	Significant variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2022 to 31/12/2022) (NHSBSA)	8.1%	8.8%	8.1%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2022 to 31/12/2022) (NHSBSA)	5.63	5.66	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	27.3‰	65.3‰	130.3‰	Significant variation (positive)



Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2022 to 31/12/2022) (NHSBSA)	0.32	0.44	0.56	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	4.0‰	5.4‰	6.8‰	Tending towards variation (positive)

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	P
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	P
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	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	N/A
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	P
For remote or online prescribing there were effective protocols for verifying patient identity.	Not applicable

The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>The practice held blank prescriptions on site, and these were kept in a secure area of the practice. We did not see evidence that there was an effective monitoring system of how blank prescriptions were distributed and no evidence of how prescriptions distributed within the practice were kept secure despite asking.</p> <p>At the June 2022 inspection, the inspection team identified a number of issues in relation to medicines management at the practice. These issues included non-qualified members of staff administering medicines to patients prior to obtaining written consent from a GP, lack of clinical supervision for non-medical prescribers and lack of appropriate monitoring for patients on specific high-risk medicines.</p> <p>At this inspection dated 3 and 9 May 2023, we found that the provider had put in place systems that showed that there had been improvements made to managing medicines at the practice. We found that Patient Specific and Patient Group Directions (PSD/PGD) were in place to allow appropriately qualified staff to administer medicines to patients (subject to patient consent).</p> <p>A system had been put in place to monitor the work of the non-medical prescribers at the practice. We saw evidence that one of the GP partners held monitoring sessions with clinical pharmacists who worked at the practice. Whilst the evidence showed that the monitoring of work by a GP partner was occurring, the inspection team was not clear how often these sessions occurred. Evidence we were provided with referred to existing and staff who no longer worked at the practice.</p> <p>The practice had a prescribing policy which was viewed by the inspection team, and we identified that prescribing at the practice aligned with the policy.</p> <p>The practice had a process for the management of information about changes to a patient's medicines including changes made by other services, however this was not always completed in a timely manner. The practice recorded the delay in processing these changes as significant events.</p> <p>Our remote clinical records review revealed that there had been improvement by the practice in the management of patient medication at the practice. We found that patients on high-risk medicines were receiving appropriate monitoring in most cases. The inspection team looked at the practice prescribing of specific type of medicine for persons with high blood pressure/ heart problems/chronic kidney disease. Our review identified that 462 patients at the practice had been prescribed this type of medicine and that 15</p>	

patients potentially had not received the required monitoring for persons taking these medicines. We looked in detail at five patient records and identified that three patients had been moved to short prescriptions (up to seven days) and recalled to the practice to obtain blood tests and blood pressure readings, one patient had been recalled to the practice to obtain a blood test and the final patient did not require any action as their current prescription was in date. We did note that one of the patients recalled to the practice most recent blood pressure reading had taken place in 2016.

**Track record on safety and lessons learned and improvements made**

**The practice learned and made improvements when things went wrong, however this needed embedding fully.**

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	P
Staff knew how to identify and report concerns, safety incidents and near misses.	P
There was a system for recording and acting on significant events.	P
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	P
Number of events recorded in last 12 months:	16
Number of events that required action:	16
<p>Explanation of any answers and additional evidence:</p> <p>We viewed four of the 16 recorded significant events and found that the practice had a system and documents in place to effectively record the event and the subsequent actions taken by the practice. The significant event documents we viewed were fully completed by the practice, highlighting why the event happened, what was done well, what could be done better and learning points from the event.</p> <p>There was also a risk management question allowing the practice to identify the likelihood of the event re-occurring based on changes implemented.</p> <p>Significant event records were managed by the practice manager and stored on the practice online information management system. Whilst we identified that there was a system to identify and report concerns, safety incidents and near misses, this system had been introduced in late 2022 after the arrival</p>	

of the new practice manager and had not yet been fully embedded within the practice's governance systems.

We asked the practice to provide us with copies of the last three all staff meeting minutes. We used these meeting minutes to cross check whether significant events were discussed at all practice minutes and found that only one set of meeting minutes had details of significant events discussed. This evidenced to the inspection team that there was not consistent monitoring of information and action on information to improve safety at the practice

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

Event	Specific action taken
Prescribing error meant patient was prescribed same-make topical cream instead of eye-drops	Once the error had been identified at the practice by one of the clinical pharmacists, the local chemist (where the prescription had been sent) was contacted and asked not to dispense the prescription, as the practice would be sending over a new prescription with correct item listed.
Patient medication not updated accordingly following hospital letter sent to practice stating change of medicine dosage	When the dosage error was identified, practice contacted patient and informed them that they need to collect the updated dose from their nominated pharmacy as soon as possible.

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>The practice was able to describe how safety alerts were managed within the practice and we were told that the practice manager also sent these through to all clinical staff. The clinical pharmacists at the practice were responsible for running clinical searches based on the alerts and actioning information relating to relevant safety alerts.</p> <p>The GP partners told us that they also reviewed medicines safety alerts for discussion with the clinical pharmacists and that monitoring the alerts was part of the GP partners review of the clinical pharmacists' work.</p> <p>The inspection team undertook a search of a Medicine and Healthcare Regulatory Agency (MHRA) alert relating to a rare side effect of a type of oral medication used to treat type 2 diabetes which could lead to</p>	

an infection, which if not treated quickly, could be life threatening. We looked at five patient records who were being prescribed this type of medicine and found that all five patients had been contacted by the practice to inform them of the identified risk of taking this type of medicine.

## Effective

## Rating: Requires Improvement

*At our last announced inspection of this provider on 30 June 2022, we rated the provider as inadequate for the provision of effective services as we found the practice did not have adequate systems and/or processes in place. This was evidenced through a range of concerns relating to the management of patient needs not being assessed in line with evidenced based guidelines, the lack of systems to keep clinicians up to date with current guidance, limited monitoring of outcomes of care and treatment for patients and inadequate staff training.*

*At this inspection held on 3 and 9 May 2023, we found that the practice put in place systems to ensure treatment and care provided was done so in line with current legislation thereby mitigating a number of risks to patient health, clinical audits were undertaken which demonstrated improved outcomes for patients, staff had the skills, knowledge and experience to carry out their roles and the practice could evidence that they sought consent to provide treatment.*

*The inspection team had concerns at this inspection relating to the way in which the monitoring of the work of staff was recorded, the low uptake of childhood vaccines (according to unverified data), the lack of nursing knowledge relating to administration of a particular vaccine and limited evidence of consistent, coordinated, person-centred care when patients moved between services.*

*As a result of the improvements made by the practice as identified at our recent inspection, the practice is now rated as requires improvement for the provision of effective care.*

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

### **Effective needs assessment, care and treatment**

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

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

Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.2	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.3	P
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.	P
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Not assessed
The practice prioritised care for their most clinically vulnerable patients.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our June 2022 inspection, we identified that the provider did not have several systems in place assure the inspection team that they were providing effective, timely and safe care to patients registered at the practice. These systems included lack of monitoring for patients with long-term conditions, missed diagnosis by clinicians, patients records not being correctly coded with their diagnosis and patient records being noted as having had clinical reviews without speaking to or seeing a clinical member of staff.</p> <p>At this inspection held on the 3<sup>rd</sup> and 9<sup>th</sup> of May 2023, we found improved clinical management of patients by qualified staff. We saw evidence that monitoring for patients with long term conditions was happening because of having up-to-date patient registers to identify these patients. We viewed five patient records diagnosed with diabetic retinopathy with a glycated haemoglobin (This is when glucose (sugar) in your body sticks to your red blood cells) reading of above 74mmol and found that all five patients were monitored appropriately. One patient did not have a diabetic medication reviewed noted in their patient records following their most recent blood glucose level test, despite their record being coded as having a medication review within the last 12 months.</p> <p>The inspection team conducted several clinical searches on the 3<sup>rd</sup> of May including searches relating to potential missed diagnosis and to identify if medication reviews conducted during the past three months were undertaken correctly and by appropriately qualified staff. On both searches, we found that the practice had again improved their management of clinical conditions following the June 2022 inspection.</p> <p>A clinical search of patients who had received two or more courses of rescue steroids (usually prescribed for patients diagnosed with asthma or chronic obstructive pulmonary disease (COPD) identified 8 out of 336 patients as asthmatics who had their patient record coded correctly as receiving two or more courses of rescue steroids.</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.
- 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.
- We conducted a clinical search focused on patients over 70 who were receiving anti-inflammatory (to reduce pain and/or inflammation) /anti-coagulant or antiplatelet (to prevent blood clots) medicine. Our search identified 21 patients out of 67 who were not prescribed anti-acid medication alongside the anti-inflammatory/anti-coagulant/antiplatelet medicine. We looked further at five of the 21 records identified and identified that all five patients were taking anti-acid medication, but two patient records were not coded correctly to identify that the anti-acid had been prescribed.
- 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 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.
- As part of our clinical searches, we identified eight patients diagnosed with asthma who had two or more courses of rescue steroids during the past 12 months. We looked at six patient records and saw that only one patient had not received an asthma review. This patient's last review was undertaken in 2021.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

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)	127	158	80.4%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	137	164	83.5%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC)	136	164	82.9%	Below 90% minimum

(i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)				
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)	134	164	81.7%	Below 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)	77	130	59.2%	Below 80% uptake

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

Any additional evidence or comments
<p>We obtained unverified recent data from the practice which showed a decrease in the uptake of childhood vaccines compared with figures in the table above.</p> <p>The practice unverified data showed that the practice had not achieved the required 80% and 90% for the first three categories on the table, 58% had been achieved for children aged 2 who received one immunisation dose of the MMR vaccine and 54% for children aged 5 who received two immunisation doses of the MMR vaccine.</p> <p>The practice had a recall system in place to contact parents to bring their children to the practice when vaccinations were due. Opportunistic vaccinations were undertaken (subject to consent) if the patient was at the practice for a separate issue.</p>

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)	51.7%	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)	56.2%	N/A	70.3%	N/A

The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (9/30/2022 to 9/30/2022) (UKHSA)	61.6%	N/A	80.0%	Below 70% uptake
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)	35.3%	53.0%	54.9%	No statistical variation

**Any additional evidence or comments**

The practice had a recall system in place for women who did not attend the practice for cervical screening. Unverified data from the practice showed that achieved an uptake of screening with 63% of women aged between 25-49 having been adequately screened within a specified period.

We asked the practice to provide us with figures for women aged 50-64 who had been screened, but we were not provided with figures to show whether there had been an increase or decrease in the practice achievement for this age range.

**Monitoring care and treatment**

**The practice had a 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
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>We asked the practice in advance of our visit to provide us with evidence of clinical audits or quality improvement activity conducted within the last 24 months. We received copies of five clinical audits. We looked in depth at a clinical audit which focused on the number of patients who were being prescribed</p>	

amlodipine and simvastatin at 40mgs. The audit was undertaken following a drug safety alert issued by the Medicines and Healthcare Products Regulatory Agency (MHRA) in 2014 which identified the increased risk of muscle damage when co- prescribing the two identified medicines.

The practice ran a search on their clinical system to identify patients who were being prescribed Amlodipine and Simvastatin. The search identified seven patients who continued to be prescribed these medicines at 40mgs.

The practice contacted the seven identified patients and held discussions with them regarding a change to either the dosage of their medicine or a change of medication.

The outcomes of the audit for the practice allowed them to identify seven patients that were being prescribed medicines following a medicines safety alert and to change the patient's medication in accordance with the alert. In addition, the practice identified the need to regularly monitor current and historical safety alerts to ensure that patient prescribing was being done so safely.

### Effective staffing

**The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles, but further work is needed to make systems robust.**

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	P
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	P
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	P

Explanation of any answers and additional evidence:

At our June 2022 inspection we identified that not all staff had the skill and knowledge and experience to deliver effective care, support and treatment. At that time, we found that practice had some staff who were working outside of their scope of practice and were making clinical decisions which they were not qualified to make. We also identified that there was no evidence of a formal programme of learning and/or development for staff working at the practice and that the GP partners could not assure the inspection team that there were systems in place to monitor the competence of staff working in clinical practice, such as nurses and clinical pharmacists.

At this inspection held on the 3rd and 9th of May 2023, we found improved systems around the management of staff working at the practice. Since our July 2022 inspection, the practice had undergone several staff changes, with new staff recruited throughout all areas of the practice.

We looked at four staff files and found that all but one staff file contained relevant information relating to employment history, signed contracts, references and proof of identity. The inspection team was told by the practice that the one staff file which did not contain all relevant information was for a member of staff who joined the practice shortly before our inspection. There was evidence that a reference had been requested by the practice for this member of staff.

The practice had put in place a comprehensive programme of learning and development for all staff which was to be completed within a rolling 12-month period. The practice provided us with a training matrix showing completed training for members of staff.

On the day of the site visit, we spoke to the practice nurse about the provision of childhood vaccinations, administering the Rotavirus vaccine to babies aged between 8 and 12 weeks old. The inspection team wanted to identify that this vaccine was being administered in line with national guidance. National guidance states that babies receiving the Rotavirus vaccine, should have a record of the results of the newborn screening test for Severe Combined Immune Deficiency (SCID) (conducted within the first 5 days after birth) was on the clinical record for the baby and viewed prior to the vaccine being given.

SCID is a rare condition that affects the immune system and the SCID test is performed shortly after birth, so that clinical staff are aware of any conditions relating to immunity prior to the first set of childhood vaccines being administered. We identified that the practice nurse did not check the clinical records or record on the clinical records that a screening result (via the baby's Red Book) had been seen prior to administration of the Rotavirus vaccine. We spoke with the practice nurse and provider about this and was told that the nurse would be expected to undertake updated immunisation training as soon as possible.

After our site visit, we received an email from the practice informing us that that a search had been undertaken on the clinical system using SCID to identify relevant patients, however there was no explanation what the remit of the search was and what was achieved by undertaking the search.

We noted that the provider had put in place a documented system for a GP partner to have oversight and supervision of the work of the practice nurse and the clinical pharmacists. At our June 2022 inspection, we identified that one of the clinical pharmacists had been working outside of their scope of clinical practice and the provider could not evidence how they assessed the competence of the clinical pharmacists. At this inspection, we identified that the provider had addressed our concerns regarding monitoring and assessing the ongoing competence of staff who undertake clinical duties. However, we were concerned with the system that had been put in place. Whilst we saw documented discussions between a GP partner and the clinical pharmacists (via email), these discussions were not detailed, and the email not consistently sent to those who were part of the discussion. The email did not show any discussion which followed up on issues raised at the previous supervisory meeting, therefore providing no documented resolution of issues.

The practice informed the inspection team that there was an approach for supporting and managing staff if their performance required improvement. We did not see a policy relating to this. To assure ourselves that the practice was providing support to staff whose performance had been identified as requiring improvement, we looked at a significant event that the practice had sent us (as part of the pre-inspection information) which related to a patient diagnosis that had been filed without a GP reviewing the diagnosis.

We saw that as a result of this significant event, the practice identified that new and existing administration staff required training in document management, specifying a date for the training to be completed. We cross-checked the practice training matrix with the specified training but could find no identified training completed by administrative staff. We did note that there was a similar training on records management, but this had not been completed by all administrative staff. The practice did provide the inspection team with the practice document management pathway, which outlined where/to whom documents should go, but did not specify the timescale for processing of the documents.

### Coordinating care and treatment

**Staff worked together and with other organisations to deliver effective care and treatment, but this was not always in a timely manner.**

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	P
Patients received consistent, coordinated, person-centred care when they moved between services.	N
Explanation of any answers and additional evidence:	

We asked the practice to provide us with evidence (by way of meeting minutes) of practice collaborative working with other organisations to deliver timely and effective care to patients registered at the practice. However, we did not receive any evidence to support that the practice engaged in this type of working.

We did note from the significant events log that the practice did work with other organisations to deliver care. An example of this, was where a prescribing error occurred and was identified at the pharmacy. The pharmacy contacted the practice to confirm whether the electronic prescription received had the correct item listed. The practice then reviewed the queried prescription, noting that there was an error, spoke with the pharmacy and resent a new prescription with the correct item.

Using the significant event list, the inspection team saw that patients did not receive consistent, coordinated, person-centred care when they moved between services. We looked at a significant event where it was noted that hospital communication received in the practice was not actioned until three months after the hospital communication was received at the practice.

### Helping patients to live healthier lives

**Staff were not consistent and proactive in helping patients to live healthier lives.**

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

Clinical records we viewed showed that changes to treatment or care was discussed with patients (particularly in relation to treatment changes authorised in secondary care), however the inspection team saw these discussions did not always occur within a satisfactory time period.

**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>We looked at three sets of patient notes which had been coded as containing a DNACPR decision and found that had been completed considering the patients/carers views. These decisions were saved within the patient’s clinical record.</p>	



## Caring

## Rating: Requires Improvement

*At our last announced inspection of this provider on 30 June 2022, we rated the provider as inadequate for the provision of caring services as we had concerns regarding the treatment of patients registered at the practice by staff. In addition, we saw a lack of action by the practice to act on and improve services based on patient feedback.*

*At this inspection held on 3 and 9 May 2022, we found the practice had started to address the concerns we raised at our last inspection. There were laminated posters within the waiting room which identified and signposted services within the community that patients might find useful. Staff had received appropriate training for interactions in with patients and there was a commitment by management to addressing patient concerns in a timely manner. Interpretation services were available to patients whose first language was not English to access services at the practice. The practice monitored the Friends and Family Test (FFT) to gauge patient feelings about the delivery of care provided.*

*The practice, however, had not undertaken their own patient satisfaction survey following the below average scores attained in the 2022 National GP Patient Survey and there was no immediate plan to address these scores. Whilst the practice monitored the FFT, there was no evidence that the results were being acted upon. Patient feedback received on the day of inspection, by the Commission in the months leading up to the inspection and to the practice directly, showed that patients were receiving inconsistent levels of care from the practice.*

*As a result of the ongoing improvements made by the provider, the practice is now rated requires improvement for the provision of caring services.*

### Kindness, respect and compassion

**Staff treated patients with kindness, respect and compassion but this was not consistent. Feedback from patients was mixed 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.	P
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	P
Explanation of any answers and additional evidence:	

<p>Since our June 2022 inspection, the Commission had received 13 complaints from patients in relation to their treatment and care from the practice. Several of the complaints spoke about unacceptable staff behaviours when contacting the practice. These complaints described staff as being rude and abrupt when talking to patients.</p> <p>We spoke with three patients of the day of the site visit and found that two patients had no issues with staff. The two patients found staff good when talking with them and that they treated them with dignity and respect. One patient told us that they felt disrespected by staff attitudes towards them when they contacted the practice by telephone.</p> <p>Two of the three patients we spoke with confirmed that they received timely information relating to the management of their care. Our search of some of the practice's clinical patient records found that patient care in the form of timely monitoring was occurring, which meant patients receiving timely information to manage their condition(s).</p> <p>All staff had undertaken training in the last 12 months for customer care, equality and diversity and privacy and dignity.</p>	
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Patient feedback	
Source	Feedback
Patients on site on day of inspection.	Treated with dignity, compassion, and respect when at the practice. Clinical staff will explain treatments/medication prescribed and any potential side effect(s) of treatment(s). In general, staff attitude is good but sometimes attitude disrespectful on telephone.
Patient feedback sent to CQC	We received 12 complaints from patients about the service they received from the practice. Most of the complaints focused on the lack of access to appointments when contacting the practice by telephone and the unhelpful attitude of some staff at the practice. Other complaints received told us about the practice not following up on secondary care referrals and staff personnel issues.

### 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	69.3%	78.8%	84.7%	Variation (negative)

professional was good or very good at listening to them (01/01/2022 to 30/04/2022)				
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)	62.7%	76.5%	83.5%	Variation (negative)
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)	88.5%	89.2%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	53.0%	65.7%	72.4%	Tending towards variation (negative)

	<b>Y/N</b>
The practice carries out its own patient survey/patient feedback exercises.	N

### Any additional evidence

We spoke with the new practice manager regarding efforts undertaken to get to understand patient concerns. The practice manager explained from during the time they had arrived at the practice (Autumn 2022), the management of the practice had been working to resolve the most urgent issues that had been identified at the June and October 2022 inspections.

We were told that patient feedback was important to the practice, so that it could address those concerns in a timely and effective manner. The practice now used the friends and family test (FFT) as a measure of patient satisfaction and regularly reviewed (and answered) reviews left by patients on the nhs.uk website. We noted that the practice did not display the results from recent friends and families' tests on their website.

### Involvement in decisions about care and treatment

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

	<b>Y/N/Partial</b>
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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
Explanation of any answers and additional evidence:  We noted that there were laminated posters within the waiting room which identified and signposted services within the community that would be beneficial to some patients at the practice. Similarly, the practice website signposted patients to self-referrals services such as talking therapies and stop smoking services.  The practice had access to a social prescriber. Practice staff were able to refer patients to this resource when required.	

### 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 (01/01/2022 to 30/04/2022)	77.9%	84.6%	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
Information leaflets were available in other languages and in easy read format.	Not assessed
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence:	

240 out of 430 patients registered at the practice said the service at the practice was either very good or good according to the past six month's friends and family test scores.

The practice website had a function which allowed it to be translated into approximately 90 alternative languages.

Carers	Narrative
Percentage and number of carers identified.	Not assessed
How the practice supported carers (including young carers).	Not assessed
How the practice supported recently bereaved patients.	Bereaved patients were offered counselling and appointments with the practice social prescriber or GP (if required).

### 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.	P
<p>Explanation of any answers and additional evidence:</p> <p>We noted that on the day of our site visit that the self-check in machine was not working and patients were attending the reception desk to confirm their attendance for their appointment.</p> <p>The reception desk at the practice is situated within the reception area and conversations could be heard. However, we could not hear any confidential discussions whilst we observed the area.</p>	

## Responsive

## Rating: Requires improvement

*At our last announced inspection of this provider on 30 June 2022, we rated the provider as inadequate for the provision of responsive services as we had concerns regarding the difficulties patients had reported in accessing care in a timely way. We also had concerns in the way complaints were not always addressed by the practice.*

*At this inspection held on 3 and 9 May 2022, we found the practice had started to address the concerns we raised at our last inspection. Services at the practice had been organised to increase flexibility and choice for patients and complaints were now being addressed in a timely manner. Interpretation services were available to patients whose first language was not English to access services at the practice. Patients were able to access extended appointments if they required one.*

*The practice had no immediate plan to address the 2022 National GP Patient survey scores. There was no evidence that patients had timely access to appointments and that action was being taken to minimise the length of time people waited for care, treatment or advice.*

*As a result of the ongoing improvements made by the provider, the practice is now rated requires improvement for the provision of caring services.*

### Responding to and meeting people's needs

**The practice organised and delivered services to meet patients' needs, but there were still gaps in the delivery of services.**

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	P
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	P
The facilities and premises were appropriate for the services being delivered.	P
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:	

The practice told us that patients had flexibility and choice in the delivery of their care. Appointments could be booked at a time of the patients' choosing and using a variety of methods to obtain an appointment. However, feedback from patients suggested that whilst the flexibility was available, the methods to obtain appointments did not encourage flexibility i.e. having to wait a long time before calls were answered if using the practice telephone number.

<b>Practice Opening Times</b>	
<b>Day</b>	<b>Time</b>
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	8.30am - 6pm
Tuesday	8.30am - 6pm
Wednesday	8.30am - 6pm
Thursday	8.30am - 6pm
Friday	8.30am - 6pm

- 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 told us there was liaison with the community services to discuss and manage the needs of patients with complex medical issues. We asked for evidence to show the liaison was occurring by way of meeting minutes, but the inspection team did not receive these.
- Additional nurse appointments were available until 6pm on a Monday, Tuesday and Wednesday for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was open until 6.30pm Monday to Friday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of the local GP federation.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers 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 was a registered safer surgery, allowing anyone who required GP services to access services for this location.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. Extended appointments were available to this population group as well as any other patients who required a longer appointment.

#### Access to the service

**People were not always 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.	N
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.	N
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.	P
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:	
We noted from the review of complaints received by the practice along with the information provided to us by patients of the practice, that the practice did not consistently offer timely access. Most of the complaints	



we viewed related to lack of access to the practice by telephone. These complaints were reflected in the 2022 results of the National GP Patient Survey results, where the practice achieved a score 12% lower than the national average when patients registered at the practice gave a positive response when asked how easy it was to speak to someone at the practice by telephone.

Similarly, due to difficulties in accessing services at the practice by telephone, patients were not always able to make appointments in a way that suited them. The National GP Survey Results revealed that the practice achieved a score lower than both the local Integrated Care Board (ICB) and national averages. As a result of the complaints received by the practice and information we received alongside the results of the 2022 National GP Patient Survey, the inspection team could not assure themselves that patients with the most urgent needs were able to have their care and treatment prioritised.

The practice told us that staff have been trained on the upgraded telephone system and hoped that the upgraded system would make a difference in patients being able to access services by telephone in a timely manner.

### 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 (01/01/2022 to 30/04/2022)	39.3%	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)	44.5%	50.6%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	45.2%	52.7%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or	56.1%	65.1%	71.9%	Tending towards

appointments) they were offered (01/01/2022 to 30/04/2022)				variation (negative)
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Source	Feedback
NHS.uk website (formerly NHS Choices)	Eight reviews by patients since our June 2022 inspection revealed mixed views of patient care from the practice. Positive reviews of the practice mentioned good care from clinical staff whilst the negative reviews mentioned lack of access to practice services by telephone and poor interactions with reception staff.

### 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.	12
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
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

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient unable to register new baby at practice due to conflicting information given by staff	Practice contacted patient to listen and address concerns. Baby was registered and appointment given for newborn baby vaccinations.  Learning for the practice was to have a nominated member of staff that registers and books post-natal and 6-week baby checks

	when a maternity discharge summary is received at the practice and/or process new baby birth registration requests.
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## Well-led

## Rating: Requires Improvement

*At our last announced inspection of this provider on 30 June 2022, we rated the provider as inadequate for the provision of well-led services as we found that leaders at the practice could not demonstrate that they had the capacity and skills to deliver high quality sustainable care. The inspection team could not identify a vision or credible strategy for the practice and there was no effective overall governance in place. Processes for managing risk and performance or any other issues that might arise had not been monitored and we identified that the practice did not always act on appropriate and accurate information received.*

*At this inspection held on 3 and 9 May 2023, we found that the provider had made progress on the issues identified at our last inspection. We found the provider had worked on a mission statement which included a set of values to underpin their vision, systems to ensure compliance with the requirements of the duty of candour had been embedded, lines of responsibility and systems to identify accountability had been established and processes for learning and improvement had been established.*

*This inspection also identified gaps in the provision of managing risks, issues and performance, and whilst there was a commitment to using data and information proactively to drive and support decision making, the practice did not elaborate on how this would be achieved. We did not see evidence that the provider had a system to monitor if the aims of the mission statement and its values were being achieved.*

*As a result of our findings at this inspection held on 3 and 9 May 2023, the provider is now rated as requires improvement for the provision of well-led services.*

### Leadership capacity and capability

**Leaders could demonstrate that they had the capacity and skills to deliver quality care but could not give details on how to sustain this long-term.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	P
They had identified the actions necessary to address these challenges.	P
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:	

At this inspection, the senior GP partner spoke with us about their plans for the practice which included succession planning. At our July 2022 inspection, the partners were unable to discuss succession planning with the inspection team. The senior GP partner spoke with us about future development plans once the practice had embedded new staff and implemented new procedures to facilitate improved delivery of care to patients.

Leaders could demonstrate that they understood the challenges to quality and sustainability. Following our June 2022 inspection and the overall rating of the practice as inadequate, the partners told us there was period of reflection where they were disappointed at themselves but knew that they had to work hard to improve the service. At this inspection we found joint working of the partners was occurring, however the inspection team felt that the working together was driven by the desire to get a positive re-rating and not entirely for the wider good and sustainability of the practice.

Following the June 2022 inspection, several existing staff had left the practice, which meant that at this inspection we identified that changes within the practice had not been embedded fully due to the number of new staff including a new practice manager. However, we acknowledge that the new practice manager worked closely with the GP partners to address the challenges at the practice and to improve services delivered.

We noted an improvement in use of data to improve patient outcomes and to address challenges of caring for a mixed population in an area rated index 4 using the indices of multiple deprivation (IMD), however this improvement was not always consistent.

**Vision and strategy**

**The practice had a clear vision and credible strategy to provide high quality sustainable care, but this had not been embedded.**

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	P
Progress against delivery of the strategy was monitored.	N
Explanation of any answers and additional evidence:	
The practice had established a mission statement which included a set of values. The statement described the practice intention to achieve best outcomes for patients, achieved through offering a range of services	

assisted by approachable staff. The mission statement had been established since our last full comprehensive inspection and not all of the content in the statement had been achieved. The statement and values had not been fully embedded within the practice and there was no evidence that all staff were involved in devising the statement as non-clinical staff we spoke with all had different responses when we asked if they understood the practice values.

The mission statement indicated that the practice had a clear view and strategy for the future, and they aspired to deliver high-quality care but due to the number of personnel changes and introduction of new governance system since the June 2022 inspection, the ability to embed the mission statement within the practice had not been fully achieved.

We did not see any evidence to show that the provider had a system to monitor if the aims of the mission statement were being achieved.

## Culture

### The practice had a culture which drove 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.	P
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:	
There have been several staff changes since our last inspection. Staff we spoke with on the day of inspection told us they worked well together. Administrative staff told us that that they would speak with the practice manager in the first instance if they had any concerns. The new practice manager had joined since our last comprehensive inspection. They told us that they wanted all staff to know that there was a no-blame culture at the practice and that incidents and events were learning opportunities to do things better if something went wrong at the practice.	

There was a commitment by the practice manager to ensure the well-being of staff by ensuring that they did not feel overwhelmed by workloads. They told the inspection team that they had an open-door policy and wanted staff to feel comfortable to approach them or the GP partners. Whilst there was this commitment to staff welfare by the practice manager, we did not see the same commitment from the GP partners to the practice manager as the inspection team noted the practice manager was working increased hours to implement new governance structures at the practice.

At this inspection we did not find evidence of closed cultures within the practice as identified at our last inspection. This was in part due to the arrival of new staff at the practice and the departure of long-standing staff. Our discussion with the practice manager gave us some assurance that the practice encouraged candour, openness and honesty, which was lacking at our last inspection. There was WhatsApp staff group for communications (not patient related).

The practice had implemented systems to comply with the requirements of the duty of candour and this was evidence through three significant events on the log that we viewed.

All but three members of staff had recently completed equality and diversity training.

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

Source	Feedback
Staff member	Very supported by GP partners, GPs and practice manager. Can approach anyone in the practice for advice either in person or by using Teams
Staff member	Always opportunity to raise concern as I can go to the practice manager. We get and give support amongst staff.

**Governance arrangements**

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y

There were appropriate governance arrangements with third parties.	P
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The inadequate governance arrangements we found at our July 2022 inspection in relation to safeguarding, clinical supervision and oversight, as well as monitoring of professional registration and appraisals had been addressed.</p> <p>The provider had established governance structures which at the time of our inspection had been in place (in some cases) between eight to ten months. We found improvements had been made since the June 2022 inspection in relation to having governance systems and processes in place. An example of this was we found the provider now had a safeguarding policy with a safeguarding pathway addendum in place. Clinical supervision was occurring, and we saw evidence of this (albeit with some refinement needed to the system of recording these supervisory sessions). Recruitment records needed more work to ensure that the provider had complete records for staff whether they be permanent or locum.</p> <p>Administrative staff were clear about their roles and responsibilities under the supervision of the new practice manager. Clinical staff (practice nurse and clinical pharmacists) we spoke with were also clear on their roles and responsibilities. These members of staff told us that they would refer upwards any clinical issues they required further advice on. Our clinical records search found no issues relating to either the clinical pharmacists or the practice nurse working outside of their scope of practice.</p> <p>There were arrangements to ensure effective dissemination of information such as practice and clinical meeting minutes to absent staff when these meetings occurred.</p> <p>We saw evidence that showed how the practice managed governance arrangements with third parties; however, this evidence was limited to companies related to building or equipment maintenance. There was no evidence provided to show joint working with integrated care teams or other community services.</p>	

**Managing risks, issues and performance**

**There were processes for managing some risks, issues and performance, however it was not clear if these processes were effective.**



	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	P
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.	P
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	P
When considering service developments or changes, the impact on quality and sustainability was assessed.	P
<p>Explanation of any answers and additional evidence:</p> <p>The provider had put in place some systems to underpin essential standards to identify, manage and mitigate risk. We saw risk assessments for fire and health and safety had been undertaken by external contractors. Internal assessments of emergency medicines and infection control measures had been completed and documented since our July 2022 inspection.</p> <p>There was now an assurance of competence of practice staff carrying out clinical roles to be working within scope of their role. The system to assure of competence required further embedding within the practice. There was now a process of oversight to ensure staff training was undertaken periodically, that there was an effective induction program for locum and new staff, as well as a system of identifying and handling of significant events and patient safety alerts. The practice had also employed personnel to summarise patient records.</p> <p>A programme of clinical and internal administrative audits with quality improvement outcomes had been established. Again, this was a system which had been implemented following our June 2022 inspection and needed to be embedded fully as part of a performance management programme. There were no recent patient surveys undertaken which meant there was no process to identify or manage practice performance in this area.</p> <p>The practice did not have a register (or similar document) which highlighted any external or internal risk to the running and delivery of services at the practice. The establishment of a risk register would have allowed the practice to put in place plans on how to address patient concerns regarding access using the results of the 2022 National GP Survey results.</p> <p>We identified through our review of the significant event log that there were still gaps in the management of monitoring of responses relating to referrals of patients to other healthcare services. This was raised with the provider at our June 2022 inspection. Similarly, we were concerned that reception staff did not have the</p>	

skills to identify a medical emergency such as sepsis, despite having recently received sepsis awareness training.

The practice had made efforts to adapt to how it offered appointments to meet the needs of patients. As a result of the pandemic, the practice continued with several telephone and face-to face consultation. Reception staff were able to offer patients appointments an extended range of staff (GP's, practice nurse, clinical pharmacists, healthcare assistant and social prescriber). Despite the range of staff at the practice that patients could consult with, patients continued to face difficulty accessing appointments.

**Appropriate and accurate information**

**There was a commitment to using data and information proactively to drive and support decision making.**

	Y/N/Partial
Staff used data to monitor and improve performance.	P
Performance information was used to hold staff and management to account.	P
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was some evidence that the practice used data to monitor and improve performance. This was demonstrated in the use of the clinical system to identify patients who required medicines reviews and annual reviews, as well as conducting internal governance reviews. Since our last inspection, the practice had undertaken clinical audits to ensure that specific groups of patients were receiving the correct care in relation to prescribed medicines. We saw positive outcomes of the clinical audits, but no narrative on how this data would continue to be used in the future to ensure continued good outcomes for patients.</p> <p>Performance information was used to hold staff and management to account, but this was inconsistent. The weekly monitoring of the work of the clinical pharmacists was an example of how the GP partners were using information to discuss performance with staff. However, the significant event log showed that not all recorded medicines related event were discussed at the next clinical meeting to ensure that the information was used to ensure that an occurrence of the same/similar event would be minimised.</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.	P
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.	Not assessed
<p>Explanation of any answers and additional evidence:</p> <p>Patient records continued not to be held in line with guidance and requirements of good record keeping. We had concerns regarding the number of medical records waiting to be summarising of service, although the practice had employed new staff to undertake this task.</p> <p>The practice website had information relating to the way the practice used patient data to manage their care in line with the GDPR and the Data Protection Act of 2018. The website had links to the practice transparency statement and the practice privacy notice.</p>	

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

**The practice did not involve 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.	P
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	P
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	N
Explanation of any answers and additional evidence:  We saw that the practice responded to patient online reviews (nhs.uk) and patient feedback when the practice contacted patients because of a complaint raised..  Patients we spoke with on the day of the inspection were mainly positive about the care received, although one patient told us that they felt disrespected by reception staff when they contacted the practice by phone.  We did not see any evidence of how the practice worked with stakeholders to build a shared view of challenges and of the needs of the population.  There was no Patient Participation Group in place, but the practice told us that they had plans to reconvene this group in the near future.	

**Continuous improvement and innovation**

**There were systems and processes for learning, continuous improvement and innovation, but these were limited.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	P
Learning was shared effectively and used to make improvements.	P
Explanation of any answers and additional evidence:	

The practice was now conducting clinical audits to improve outcomes for patients. There was no evidence of how the audits undertaken would contribute to continuous improvement of outcomes for patients. We did not see evidence within the clinical or practice meeting minutes discussions relating to clinical audits undertaken.

Monitoring of the practice nurse and clinical pharmacists now occurred. Evidence of learning was seen with clinical pharmacists discussing medicines reviews of individual patients with a GP partner at their supervisory session.

The significant events log was being used to capture all clinical events. We saw evidence that events were being recorded regularly and that any discussions because of the event and any learning from the event was recorded within the log. We did not see evidence that learning was shared amongst all practice staff at practice meetings.

**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.