

Care Quality Commission

Inspection Evidence Table

The Highlands Practice (1-541744674)

Inspection date: 25 July 2022 – 01 August 2022

Date of data download: 25 July 2022

Overall rating: Requires Improvement

At this inspection in July 2022, we rated the practice as Requires Improvement because:

- The provider was unable to demonstrate that appropriate monitoring of patients prescribed high-risk medicines was being carried out consistently when prescribing.
- There was evidence that the process for managing safety alerts was not being followed appropriately to ensure patients were protected from harm.
- The provider had failed to ensure that all persons employed complied with the completion of mandatory training.
- People using the services did not always receive care or treatment that was personalised specifically for them.
- The oversight of systems and processes intended to deliver safe and effective care to patients was not fully embedded.

Safe

Rating: Requires Improvement

At this inspection, we rated the practice as Requires Improvement for providing safe services because:

- There were shortfalls in the completion of medicine reviews for patients prescribed high-risk medicines.
- There was evidence that not all staff had completed training relevant to their role in line with national guidance.
- Safety alerts had not been adequately monitored to ensure safe prescribing.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse, but training was not in line with national guidance.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Y

Safeguarding	Y/N/Partial
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a safeguarding system and policy in place for vulnerable adults and children which was reviewed in July 2022. There were designated safeguarding leads, with local arrangements and key contacts for making a safeguarding referral. • Senior managers, clinicians and practice nurses discussed safeguarding within regular monthly meetings. Relevant information was recorded in patient records. Meeting minutes were recorded and available to staff who were not in attendance. • There was evidence that not all staff had received safeguarding training appropriate to their role and lack of oversight for training completion meant there was a risk that patients would not be identified as needing protecting from abuse. For example, we found from the training records provided by the practice, there was one GP who had not completed level three safeguarding vulnerable adults, one clinical pharmacist, one nurse practitioner and one healthcare assistant who had not completed level three safeguarding children or vulnerable adults as recommended by the intercollegiate guidance for safeguarding published in January 2019. Two GP's were on long-term absence, in which mandatory training was suspended until planned return. • A mixture of clinical and non-clinical staff members had chaperone responsibilities as part of their role. Those staff members had completed relevant training and Disclosure and Barring Service (DBS) checks or risk assessments had also been conducted. • The practice had a system to identify vulnerable patients on record. Other community care professionals such as health visitors, school nurses and social workers were invited to attend monthly safeguarding meetings which involved the discussion of these patient groups. This was co-ordinated by a dedicated safeguarding administrator employed by the practice. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a recruitment policy in place, which had been updated in January 2022. This included how the practice processed personal data in accordance with the General Data Protection Regulations (GDPR). The practice had maintained records in relation to role specific immunisation for clinical staff. • The practice had a dedicated induction programme for new GPs and clinical staff including safeguarding procedures, infection prevention and control and fire safety. • We carried out recruitment checks in relation to four members of staff which contained all of the required information as per practice policy, including Disclosure and Barring Service (DBS) checks. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: March 2022	Partial
There was a fire procedure.	Y
Date of fire risk assessment: July 2022 Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Health and safety risk assessments had been carried out in March 2022. This included injury risks of slips and hazards, manual handling, premises safety, electrical, storage as well as workforce physical health. As this was the first health and safety review under the Sovereign Health Partnership, further evidence of bookings for health and safety risk assessments to be carried out at the branch sites were scheduled for August 2022 to ensure oversight of systems to identify and mitigate changes to risk to service users and staff. Portable appliance testing had been completed by an external provider in April 2022 whilst equipment calibration had been completed in September 2021. Legionnaire servicing had taken place in December 2021. Records of weekly water checks and flushing records were completed by staff. There was evidence of six health care cleaning products on the premises that did not have the required Controlled Substances Hazardous to Health (COSHH) data sheets to give guidance to staff should there be incidents relating to health and safety. Immediately after the inspection, the provider rectified this and plans were in place to improve oversight in this area. The fire risk assessment conducted deemed the premises compliant. We saw evidence of recommended health and safety maintenance bookings for the fire alarm servicing and emergency lighting scheduled to take place in August 2022. The practice had conducted fire evacuation drills and provided fire evacuation learning at all sites, the latest records observed, July 2022. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met, but not all staff had received training in infection prevention and control.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: June 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> An infection prevention & control (IPC) audit was completed in June 2022. There was a schedule for this to be completed annually. Standard operating procedures were in place and 	

had been reviewed by the practice's IPC lead. The IPC lead was able to demonstrate a comprehensive understanding of infection, prevention and control and their role in ensuring the practice complied with national guidelines.

- Issues identified within the IPC audit had been actioned. The practice received support from the local commissioners in relation to infection control requirements for domestic cleaners in General Practice due to a change in external cleaning contractors. Audits on cleaning standards had previously not been completed prior to the most recent IPC audit. This has now been completed by the provider.
- The practice identified through the IPC audit that there were no carpet cleaning facilities for the three sites. The carpets had last been deep cleaned in May 2021. We saw evidence that a deep clean of the carpets for all three sites was booked for August 2022. There were plans in place to replace all carpets with vinyl flooring within the business service improvement plan by 2023.
- The practice had a plan in place to hold immunisation status for staff members from across the three sites, this had not taken place at time of inspection due to recent merger.
- Appropriate measures were in place to ensure the premises was clean and that guidance was available for procedures relating to aseptic non-touch technique, hand washing, clinical waste, needlestick injuries, personal protective equipment (PPE) and risks associated with COVID-19.
- There was evidence that not all staff had received IPC training appropriate to their role and lack of oversight for staff completion meant there was a risk that patients may not receive safe care and treatment.

Risks to patients

There were some 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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was active recruitment for an additional salaried GP and advanced nurse practitioner (ANP) to assist with providing appointments under the appointment triage model to meet patient demand across the three sites. At the time of inspection, there were three clinical staff members on long-term leave. Their sessions had been covered by remote locums and a new minor illness nurse. The practice was supported by several additional roles reimbursement scheme (ARRS) staff employed by Sovereign Health Partnership, including four pharmacists, two pharmacy technicians, four social prescribers, two musculoskeletal (MSK) practitioners and a health coach. The practice employed a GP, two paramedics and an advanced nurse practitioner and a care co-ordinator within the dedicated complex care team that supported home visit appointments. • There was a recruitment policy for new members of staff, including an induction procedure for training and guidance for locum and temporary staff. 	

- There was evidence of staff completing additional training for responding to medical emergencies, for example, sepsis management.
- The provider merged practice sites in October 2021. The assessment for the impact of staffing cover on patients had been addressed and improved. We saw that staff rotas for clinical and non-clinical staff were planned four weeks in advance. Annual leave was planned for key holidays for GP's and clinical staff six months in advance, locum GPs were booked where needed. Feedback from staff indicated that there were appropriate systems in place for managing staff absence but appropriate cover for annual leave was a challenge due to the reduced staffing capacity constraints against patient appointment demand. Following the inspection, the provider told us annual leave for non-clinical staff groups was covered through a mixture of overtime, cross cover from other teams of multi-skilled team members, through expanding the workforce with student in the summer and through short term re-prioritisation of roles, such as, pharmacy technicians covering prescribing clerks.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• There was an administration team who were responsible for the practice referrals, clinical coding and summarising records.• Two-week wait referrals, an urgent request to the hospital from the practice due to cancer related symptoms, had been prioritised and there was a process to ensure administrative staff members checked these daily.• There was a clear documented approach to the management of test results. Staff we spoke with were aware of their roles in relation to test results and tasks were set for clinicians to review these on the same day.	

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.48	0.72	0.79	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). (01/04/2021 to 31/03/2022) (NHSBSA)	9.0%	10.1%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)	5.54	5.71	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	94.8‰	113.5‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.18	0.56	0.60	Variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	7.2‰	9.1‰	6.8‰	No statistical variation

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

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

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Clinical supervision was given by the practice's lead GPs, providing oversight of performance and nurse prescribing was within scope of practice to ensure safe care and treatment. Audits and conversations were recorded. During this inspection we undertook remote searches of the practice's clinical patient records system to determine whether patients who had been prescribed high-risk medicines had been appropriately monitored and reviewed. We found 24 patients had been prescribed Lithium; a medicine used to treat mood disorders. Three of these patients did not have a record of having their Urea and Electrolytes (U&E), Calcium and Thyroid function (TFT) blood test and/or weight/body mass index (BMI), within the previous six months, as well as mental health review within the previous 12 months. The ongoing monitoring of these medicines is important as the correct and safe dosing is determined by, and affects, the level of kidney and thyroid function. Side effects from lithium toxicity can provide mild to severe symptoms, regular assessment can ensure amendments to the dosage prescribed are within safe treatment. A high-risk medicine search identified 19 patients who had been prescribed Amiodarone, a medicine used to treat or prevent heart rhythm disorders, such as atrial fibrillation. Of those 19 patients, we found two had not received appropriate liver function and/or TFT blood monitoring in the previous six months. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> • We identified 378 patients had been prescribed Spironolactone, a potassium sparing diuretic medicine used to treat hypertension and/or fluid retention (oedema) caused by liver disease, kidney problems or heart failure. Of those, 136 patients did not have the appropriate monitoring within the previous six months. This included either or a combination of patients having a record for having their Urea and Electrolytes (U&E) and renal function checked within that time. The practice had retrospectively identified those patients and implemented an action plan to address the outstanding risk. • During this inspection we undertook remote searches of the practice's clinical records system to determine the completeness of medicines reviews for patients on repeat medicines. It was not clear from the five medical records we reviewed that patients were being contacted for review and monitored appropriately. All five records did not document what medicines were reviewed and there was evidence of out of date blood monitoring in three out of the five patient records. • The practice had a process to manage information changes to a patient's medicines made by other services, for example, the out of hours provider (OOH). • The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes. The latest available verified NHSE data showed positive trends for antibacterial prescribing against the local and national averages. • Emergency medicines were stored on a crash trolley, accessible to appropriate staff across all sites. There was a stock of medicines within a locked cupboard, with evidence of regular stock checks including a review of expiry dates. Medical equipment included a defibrillator as well as an oxygen cylinder, with a service agreement for the replacement when oxygen levels were low or expired. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong but safety alerts were not monitored appropriately.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	12
Number of events that required action:	8
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Staff were clear on their roles to raise safety incidents and how to report concerns appropriately. The practice was able to evidence learning and the dissemination of information relating to significant events. Following a significant event, the practice advised learning from the event was investigated and discussed at team meetings, where formal minutes were recorded and evidenced. 	

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

Event	Specific action taken
An incident occurred where a clinician administered an incorrect vaccination.	The incident was investigated and learning was shared to minimise the risk of recurrence. This included a change to the storage, labelling of vaccinations and an update to the vaccination protocol. The patient was assessed, risks and actions were discussed immediately following the incident. The duty of candour was appropriately applied.
An incident occurred where a patient with symptoms following a Faecal Immunochemical Test (FIT), a screening test for colon cancer, was rejected by the laboratory due to the sample not being collected properly. This led to a delay in a two-week wait referral (2WW) being processed by the practice.	The incident was reviewed at a significant event meeting. The practice developed a new protocol to educate patients on completing the FIT test. Learning had been shared with staff to minimise the risk of recurrence.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	

- There was a safety alerts policy that outlined the procedure with guidelines for actions to take when receiving alerts. The pharmacist held administrative oversight and shared actions taken in relation to each alert with the clinical lead on a monthly basis.
- During our remote clinical searches, we found 20 patients identified on a search of patients over the age of 65 who were prescribed Citalopram 40mg. Citalopram is a medicine to help treat depression. Of the five patients reviewed, two were still at risk of harm, as these patients had no discussion documented in notes and there was no evidence to demonstrate they had been contacted to mitigate the risk. This was despite a safety alert being issued in 2014 advising against patients over the age of 65 being prescribed doses of more than 20mg of Citalopram. The provider retrospectively identified those patients and an action plan was in place to review appropriately.
- We identified six patients on a search of patients prescribed Febuxostat. Febuxostat is a medicine to treat gout where patients who had been prescribed allopurinol that did not work well or cannot be treated with allopurinol. Of the five patients reviewed, three patient records had no evidence to suggest any actions had been taken. These patients required reviewing for suitability for the ongoing prescribing of Febuxostat, where other alternative medicines are available. This was despite a safety alert being issued in 2019 advising revision of prescribing due to an increased risk of cardiovascular mortality for those who also had a history of cardiovascular disease. The provider retrospectively identified those patients and an action plan was in place to review appropriately.

Effective

Rating: Requires Improvement

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

- There were a lack of systems and processes in place for monitoring patients with long-term conditions in line with evidence-based guidance.
- The practice had not met the minimum NSHE target of cervical cancer screening uptake for eligible patients.

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 but care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • GPs referred patients to secondary care and used two-week wait pathways where appropriate. • Vulnerable patients were able to access the service during the pandemic. For example, the practice developed COVID-19 "hot" and "cold" clinics, logistical clinical areas for patients that presented with or without COVID-19 symptoms. Home visit appointment triage was available 	

for patients within the local catchment area for those who could not attend the practice and met the criteria.

- Patients were given advice on what to do if their condition deteriorated, for example, call backs or contact with the out of hours service. Communications between the out of hours service was highlighted as effective and proactive when we spoke with senior clinical staff, including the transfer of discharge notifications and changes to patient's prescribed medicine.
- The provider held fortnightly education meetings with internal and external guest speakers to provide clinical evidence-based practice updates for staff learning.
- However, we identified 99 patients with asthma who were prescribed two or more courses of rescue steroids within the last 12 months. We reviewed five patient records of which three did not have routine follow-up recalls after the patients were prescribed rescue steroids. It was unclear in all of the reviewed records whether a steroid emergency card had been issued or discussed if clinically appropriate. Steroid emergency cards help healthcare staff identify patients with adrenal insufficiency and provide information on emergency treatment if the patient is acutely ill, experiences trauma, surgery or other major stressors. The practice had not followed the latest National Institute for Health Care Excellence (NICE) guidelines, where patients should be followed up within 48 hours where the patient presents symptoms of acute exacerbations of asthma if not admitted to hospital or within two working days of discharge from hospital. The practice had retrospectively identified these patients to ensure safe care and treatment was given and an action plan in place to improve the safety netting of patient recalls.

Effective care for the practice population

Findings

- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- 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 not always offered a structured annual review to check their health and medicines needs were being met. We identified issues with patient medicine reviews and the process for outstanding monitoring of long-term conditions. For example:

- We identified 160 patients with chronic kidney disease (CKD) stage 3, 4 or 5, of which 14 patients did not have the appropriate including blood monitoring, urea and electrolytes (U&E) or blood pressure recorded within the last nine months. There was evidence of some patients receiving a consultation review within this timeframe, but not all aspects of the appropriate monitoring were completed.
- We identified 1,080 patients with hypothyroidism, a condition which results in low activity of the thyroid gland. Of those, 45 patients had not received the appropriate thyroid function (TFT/TSH) blood monitoring within the last 18 months.
- The remote searches that we undertook of the practice's clinical patient records system showed that there was a lack of oversight of long-term condition management to ensure safe care and treatment was given to patients. There were some areas in which not all patients had been recalled within the target times set out in the NICE guidelines. Leaders told us reduced staffing meant acute management and high-risk clinical care took priority under the current demand. The practice invested in a GP-led triage appointment model to ensure that prioritisation was appropriate. The provider had active recruitment for more clinical staff to support in this area and planned for shared staff resourcing to be reviewed.
- Patients with learning disabilities were offered a structured annual review to check their health, physical and mental health 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.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with 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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	140	143	97.9%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation	147	147	100.0%	Met 95% WHO based target

for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	142	147	96.6%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	146	147	99.3%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	152	157	96.8%	Met 95% WHO based target

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

Any additional evidence or comments

- Clinical staff we spoke to were aware of the practice's initiative to provide further education to assist young families in the importance of these immunisations.
- The practice monitored Did Not Attend (DNA) appointments with appropriate follow-up processes.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	74.5%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	69.6%	62.8%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	73.6%	70.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	54.4%	53.3%	55.4%	No statistical variation

Any additional evidence or comments

- The practice did not meet the minimum 80% target of eligible patient uptake of cervical screening. Staff told us that due to the pandemic with the logistical demand placed on the practice to assist with COVID-19 immunisation clinics and the “hot and cold” hubs. During the pandemic, the practice restored access to cervical screening and ran clinics from one dedicated site which delivered care for asymptomatic “cold” patients. Staff were available from the practice nursing team to deliver care in this area.
- There had been staff shortages in the administrative management and clinical staff to ensure cervical screening initiatives had been continuously processed. The provider combined female health appointments with other acute or routine patient needs where possible. At the time of inspection, female health clinic appointments were available to book in advance. The practice had implemented extended access clinics on Saturday mornings to improve the uptake in this area. The provider showed us unverified data to highlight there had been further recent improvements to its cervical screening uptake meeting the 80% target.

Monitoring care and treatment

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

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

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

Any additional evidence or comments
<p>The practice had conducted a two-cycle audit in relation to the appropriate prescribing and monitoring of antimicrobials to patients with suspected urinary tract infections (UTI).</p> <ul style="list-style-type: none">• Cycle one results showed 30 patients were reviewed for UTI prescribing. Of those patients, 10 were prescribed antibiotics as per NICE guidance. Eight out of the 30 patients who had a UTI consultation, a urine dipstick test was used to confirm or reject the suspected UTI.• The practice implemented shared learning to all employed prescribers of the Public Health England (PHE) guidelines that patient mid-stream urine samples should be sent for investigation in patients aged 65 and older if antibiotics are prescribed for suspected UTI. Patients 65 and older should not have their urine locally dipstick tested to confirm diagnosis of UTI, diagnosis should be made on symptoms alone. Lead clinicians used the audit to assist with advanced nurse practitioner (ANP) supervision, establishing safe and effective prescribing patterns amongst non-medical prescribing team members. Patient education leaflets were available to support with these prescribing guidelines.• Cycle two results showed 30 patients were reviewed for UTI prescribing. Of those patients, 22 were prescribed antibiotics as per guidelines, an increase from 33% to 73%. Five out of the 30 patients who had a UTI consultation, a urine dipstick test was used to confirm or reject the suspected UTI, a decrease from 27% to 17%.• The practice had plans in place to continue to audit this area annually. Patients identified were contacted appropriately for follow-up monitoring to ensure safe care and treatment was received. <p>A two-cycle audit was completed in relation to improving the awareness and increase the prevalence of osteoporosis in patients registered at the practice to 0.6% (in line with local averages).</p> <ul style="list-style-type: none">• Baseline results in February 2022 showed there were 159 patients registered with the practice on the osteoporosis register.• Further investigation led to 435 patients being identified as possibly having osteoporosis but were not on the osteoporosis register. Patients were identified for one or more of the following factors:<ul style="list-style-type: none">• Patients aged 50-74 with a fracture recorded since April 2012 and a record of osteoporosis.

- Patients aged 75 or over with a fracture recorded since April 2014.

The medical records of all 435 patients were screened by a pharmacist, and of these, 321 met the criteria for a diagnosis of osteoporosis and their medical records were amended accordingly. The pharmacist also ran a training session with the Workflow Team to ensure improved coding of incoming clinic letters and discharge summaries.

- Cycle two results in April 2022 showed there were 483 patients registered with the practice on the osteoporosis register, 1.2% of total registered patients.
- The practice had plans in place to continue to audit this area bi-annually and to ensure that new staff in the Workflow administrative team were trained appropriately to complete coding for these patients.

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles, but oversight of staff training completion was not fully embedded.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• There was a system for staff to complete training online. There was evidence to demonstrate training deemed as mandatory by the practice had not been completed by all staff members that were essential to their roles. For example, safeguarding children and vulnerable adults, infection prevention and control (IPC), mental capacity and basic life support.• We observed records which verified appraisals were conducted with staff, performance monitored and objectives set. Staff were supported to meet the requirements of professional revalidation, including registrations with the General Medical Council (GMC) and Nurse Midwifery Council (NMC), where appropriate.• There was a recruitment policy which outlined the process for new starters. Induction checklists were in place for new staff members for probationary review. Induction guidance was available for locum and temporary staff.	

Coordinating care and treatment

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

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

- The practice had a system to manage communication between services about patients so that they received consistent and co-ordinated care. For example, meetings took place between the local Out of Hours service and the provider for the safe handover of clinical records and treatment plans of patients moving between the services. The practice used a task management system which clinicians to raise specific clinical tasks with the lead GP outside of the set daily meeting as a safety mechanism.

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was a drive to improve social prescriber links across the newly formed partnership, with three social prescribers and a health and wellbeing coach available. At the time of inspection, we saw evidence of social prescribing schemes for smoking cessation, weight management, carers support network and physiotherapy self-referral. End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Daily home visit appointments were available to those patients that were vulnerable and high risk. These were conducted by the Complex Care Team which comprised of two paramedics, an advanced nurse practitioner and a GP employed to provide care for patients registered in the local area. 	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> During a review of clinical records, we identified that consent and decision making was recorded in line with legislation and guidance. We reviewed three patients with a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) record to consider whether the DNACPR had been prepared and agreed appropriately. The 	

records were signed and authorised with the latest reviews within the required 12 month date. Treatment Escalation Plans (TEP) forms were used for end of life patients where appropriate.

Caring

Rating: Good

Kindness, respect and compassion

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

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

Patient feedback	
Source	Feedback
Observations made during the inspection	<ul style="list-style-type: none"> During the inspection, we carried out observations in the reception area where patients attended in person and administrative area where staff took telephone calls. We observed staff were helpful and courteous toward patients and were compassionate in their approach.
NHS.uk website (formerly NHS Choices)	<ul style="list-style-type: none"> At the time of this inspection, there had been 28 ratings and reviews for the period of October 2021 to July 2022. This was reflective of when the practice had completed its merger. Of the 28 reviews, 19 were one-star reviews, one three-star and eight were five-star reviews. Patients' comments identified dissatisfaction regarding access to appointments and referral delays. Comments regarding how caring staff were, was positive. Up until beginning of July 2022, the practice had responded to each review with a personalised response, invitation to discuss the feedback with the patient services manager and used themes from the feedback as part of the complaints review.
Patient feedback via 'Give Feedback on Care' on the CQC website	<ul style="list-style-type: none"> Since January 2022, CQC received 45 items of patient feedback via the 'Give Feedback on Care' section of our website regarding the practice. Of the 45 items of feedback received, the majority highlighted access to the practice was a concern. More specifically, in relation to the appointment system, issues with the telephone system and prescription access. Other themes included practice referral management and concerns with delays for these to be processed.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	92.0%	90.6%	89.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	88.9%	89.4%	88.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	97.7%	96.4%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	78.8%	83.6%	83.0%	No statistical variation

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

Any additional evidence
<ul style="list-style-type: none"> We reviewed the most recent patient feedback exercise which commenced when the provider merged in October 2021. The practice had oversight of the complaint types per month and had an action plan in place to improve the service. For example, the practice responded to the number of times patients are required to redial; keeping patients informed whilst they are waiting; reducing the demand on phone lines. The provider implemented a new telephone system integrated across all sites; updates to the patient newsletter in relation to the management of access and an action plan in place to implement a new provider website to keep patients informed on updates, the review of digital access to meet the needs of patient population groups and the future re-introduction of an online consultation system. The practice had gathered monthly reports relating to patients using online asthma reviews. In June 2022, 55 online asthma reviews were completed. The practice had received five patient feedback reviews with comments highlighting the ease of use and concise information given.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	93.5%	94.3%	92.9%	No statistical variation

	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.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had an action plan in place to implement a new practice website to consolidate information for the merger of the three practices, as there was previous CQC feedback regarding the confusion of the three separate practice websites and the support groups available. • Interpretation services were available as well as leaflets in other languages and in easy read formats. 	

Carers	Narrative
Percentage and number of carers identified	<ul style="list-style-type: none"> • In July 2022, the practice patient population list was 38,651. The practice had approximately 1,100 patients, who were also a carer; this amounted to approximately 2.8% of the practice list. Throughout the pandemic, the practice had continued to identify those patients with caring responsibilities.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> • The practice's computer system alerted staff if a patient was carer. New patient registration forms included information to highlight if patients had caring responsibilities.
How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> • Staff told us that if families had experienced a bereavement, the practice contacted them. Further advice was also offered as required and families were signposted to relevant support groups.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:	

- Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Responsive

Rating: Requires Improvement

At this inspection in July 2022, we rated the practice as Requires Improvement for the provision of responsive services because:

- Patients did not always have access to appointments in a timely way.
- Online access to GP appointments was not available for patients.

Responding to and meeting people's needs

The practice organised and delivered services that did not always meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Partial
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Online access for GP appointments was not available at the time of inspection. However, patients were able to book appointments for female health clinic appointments, blood tests and immunisations. Reviews for patients with long-term conditions were pre-booked and conducted online where possible. • Between January 2022 and June 2022, patients had contacted the CQC and reported challenges accessing the practice. Different patients highlighted their needs were not always met. Several highlighted concerns and delays with the telephone system as well as accessing appointment availability. This feedback aligned to feedback left on NHS.uk and within the complaints the practice had received. However, from June to July 2022, patient feedback left by patients experiencing the GP triage same day care service showed improvements to access. There was evidence of six five-star reviews between this period. • The practice had oversight of appointment capacity and demand through system data capture. There were daily management meetings which discussed appointment capacity and what had been booked, the telephone patient message was updated throughout the day to alert patients of the current status. The telephone system capacity was set at 30 callers in the queue at any one time. • The practice had implemented a new telephone system in June 2022, bringing together the three sites, managed by one administrative team. The practice had started to audit their telephone data to prioritise staffing covering locations where patient demand was highest. We saw evidence of additional audits such as call abandonment rates. Where there were influxes of calls abandoned, the practice prioritised staffing administrative cover. There were plans to embed and 	

evaluate this further once there was enough data trends over time. This included plans to complete daily comparisons across the three sites and to hold meetings to review performance.

Practice Opening Times	
Day	Time
Opening times:	
Monday	8:00am – 6:30pm
Tuesday	8:00am – 6:30pm
Wednesday	8:00am – 6:30pm
Thursday	8:00am – 6:30pm
Friday	8:00am – 6:30pm
Extended access:	
Saturday (The Highlands Practice site only)	8:00am – 12:30pm

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

- The practice held a patient engagement event on 24 May 2022 which included 700 members of the public and colleagues from the local commissioning group. Topics and themes were discussed ranging from the current access demands, disabling online appointment access and the current appointment triage model, with the allocation process for face to face appointments with clinicians. The practice had published further details and information for patients from the event via the practice website and through patient newsletters. Staff and patients who attended the engagement event reported it worthwhile and informative, with the reflected aim of holding future scheduled events.
- The practice had initiated a project to increase the number of patients and demographics within the partnership focus group so that a well represented group could give specific service feedback moving forward. This was to improve the awareness of the needs of the practice population so that changes could be implemented to provide a responsive service.
- The practice offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice held responsibility to provide healthcare services to seven local care homes and multiple learning disability homes. Dedicated ward rounds were held weekly where clinicians would manage the needs of these patients in residential care settings.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.

Access to the service

People were not always able to access care and treatment in a timely way.

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Partial
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	Partial
There were systems in place to support patients who face communication barriers to access treatment	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Complaints received by CQC during the period between January 2022 and June 2022 highlighted the length of time it took for telephone calls to be answered, inbound calls not being answered and being unable to book or speak to a clinician. There were also concerns regarding a lack of clarity and information on the different methods and systems to access an appointment. We discussed these themes with the practice during the inspection and the practice demonstrated to us how they had assessed and monitored how patients accessed services across the three sites. The practice communicated changes in access arrangements via monthly patient newsletters and the practice website. The appointment triage model provided same day response to unplanned and urgent care for patients. Patients could not book routine GP appointments in advance. This was due to the provider deeming it unsafe to continue online access for routine, urgent and unplanned care and to ensure oversight of appointment demand was managed appropriately whilst there was reduced clinical staff employed and available. The provider responded to patient feedback about access by moving to this appointment model. There was a patient engagement event in May 2022 to rebuild the trust and responsiveness when patients had a new medical problem. Online prescription access was available, the provider published a service level of four days for repeat prescriptions. At the time of inspection, staff told us there was a three to five day prescription processing delay. 	

- In response to feedback from elderly and vulnerable patients about digital access, the provider introduced the option to visit the practice in person to request being added to the daily triage list in addition to contact via the telephone.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	36.3%	N/A	67.6%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	52.1%	70.4%	70.6%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	48.6%	65.4%	67.0%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	69.7%	82.6%	81.7%	Tending towards variation (negative)

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care. Full oversight of complaints management had not yet been fully embedded.

Complaints	
Number of complaints received in the last year.	105
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	4
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice implemented a new complaints management system in April 2022. Since the provider merger of the three practice sites in September 2021, to April 2022, the practice had to retrospectively add complaints from this period, there was evidence that some records did not contain all of the correspondence responses showing the full audit trail. The practice had a complaints policy in place. The managing director along with the complaints manager held oversight of complaints. We reviewed five complaints, of which four were provided with satisfactory responses within practice policy timeframes. One reviewed complaint although initially acknowledged, did not receive the appropriate follow-up contact within 28 days. The practice was still investigating the complaint at the time of inspection. At the time of inspection, there were 28 open complaints with the oldest open complaint from May 2022. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
The telephone line was regularly busy, that speaking with a member of staff required long waiting times without any updates.	<ul style="list-style-type: none"> Installation of the new phone system in June 2022 allowed for keeping waiting patients better informed. Reception staff were given additional support for signposting patients and collecting triage information to assist with the appointment capacity demands.
The practice website was outdated and did not provide the latest information about the practice.	<ul style="list-style-type: none"> Patient updates and correspondence from engagement events had been communicated in patient newsletters and practice website. The practice had put an action plan in place to consolidate information from the three practice site websites into one new website. The practice was in the process of reviewing how it would reintroduce the option to book appointments online.

Not all staff were aware of changes made to the service.	<ul style="list-style-type: none"> • Clinical governance meetings were recorded for playback to those staff members who were unable to attend.
Staff shortages have hindered appointment capacity against patient demand.	<ul style="list-style-type: none"> • At the time of inspection, the practice had active recruitment for an additional GP, Advanced Nurse Practitioner (ANP) and pharmacist to support the management of patients with long-term conditions.
Reasonable adjustments for patients with protected characteristics were not always considered.	<ul style="list-style-type: none"> • Designated high visibility yellow chairs had been added to all patient waiting areas at all three sites for patients who are visually impaired.

Well-led

Rating: Requires Improvement

We have rated the practice as Requires Improvement for providing well-led services because our inspection identified oversight of systems and processes intended to deliver safe and effective care to patients was not fully embedded.

Leadership capacity and capability

Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The three practice sites faced challenges in providing sustainable care to its patient population and merged as one provider in September 2021. Leaders had started to work to create shared governance arrangements, including practice policies, procedures and staffing provisions despite the ongoing challenges. For example, the provider took the decision to halt online access due to the overwhelming volume was impacting on safe delivery.• Two part-time salaried GPs were on long-term leave at the time of inspection. Their sessions were covered by remote locum GPs and a minor illness nurse. There was active recruitment for an additional GP and a pharmacist to meet the growing demands of the practice population.• The practice had oversight of a succession plan, reviewed in July 2022, including leadership development, career progression and a plan to replace future staff leavers.• Staff feedback was obtained annually and staff felt that leaders were visible and approachable.	

Vision and strategy

The practice had a clear vision and credible strategy, but new measures had not yet been fully embedded.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	

- There was a mission statement displayed on the practice's website which staff told us they knew about. Staff told us they were proud to work for the practice, albeit there were challenges placed with workload due to reduced staffing numbers.
- There was a business strategy last reviewed in June 2022 for the period 2021-2024. This included performance measured against strategies for the premises, staffing, training, IT, profitability, communication, ensuring active patient participation and service development.
- The practice were aware of how clinical staffing levels were affecting appointment capacity. There was a plan in place to mitigate staffing concerns whilst active recruitment was in place. For example, the practice is recognised as a training provider, with two clinical leads at all sites. They were supported by an education environment lead for GP registrars assigned to the practice. The practice was also registered with the national GP retention scheme. The practice was further supported through the national Additional Roles Reimbursement Scheme (ARRS), where clinicians were recruited to assist with alternative patient access to care.
- The practice had a set of values developed with staff to support the overall mission statement.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice demonstrated transparency around access and what actions were being taken through updates to practice website articles. In particular, the decision to disable online access to appointments. • The incident reporting system complied with the requirements of the duty of candour. • Staff told us they felt able to speak up openly if they had any concerns and the working environment was friendly and supportive. Staff had access to a Freedom to Speak Up Guardian and a mental health first-aider. • The practice had a whistleblowing procedure available for staff to access electronically and in paper format at the practice. • Equality and diversity training was deemed by the practice as mandatory for all staff. There was evidence that six members of staff had not completed this module at the time of inspection. 	

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

Source	Feedback
19 staff feedback forms	Common themes included: <ul style="list-style-type: none"> • Staff were friendly and supportive. Actions were responded to swiftly. • More patient appointments were required to meet demand. • The practice needed more clinical and non-clinical staff to meet demand, workload was challenging. • There were visions to drive service improvement and to share all standardised processes across all three sites. Practice management needed time to embed governance arrangements.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support management decisions. However, governance arrangements were not fully embedded.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Following staff consultation to merge the three practice sites, all members of staff working for the practice were issued with new employment contracts, job descriptions and their roles and responsibilities. • Care pathways and protocols evidenced within records for patient medicine reviews were not always followed. • Current practice protocol for reviews for patients with long-term conditions were not always effective to ensure safe care and treatment. The provider had failed to ensure staff completed these processes in line with national guidance. The practice had an action plan to review medicine management procedures and the criteria for patient medicine reviews subsequent to inspection findings. The current practice protocol for reviews for patients with long-term conditions had not been fully aligned or embedded across the three merged sites. • There was evidence that the process for managing patient safety alerts was not always followed appropriately to ensure patients were protected from harm. Including the management of Medicines & Healthcare products Regulatory Agency (MHRA) alerts to demonstrate safe practice. 	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • A quality improvement audit program was in place, which was reviewed by the practice management team. • A business continuity plan was in place which gave guidance to staff for the preparation of major incidents. Impact of care was assessed and involved external stakeholders, for example, the local care homes attached to the practice. • The practice had a system in place to liaise with specialists when looking at patient management for specific conditions such as dermatology or musculoskeletal (MSK) conditions. • There was a system in place and clear lines of accountability for the supervision and appraisal of staff. There were opportunities for staff to undertake continuous professional development (CPD). 	

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

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y

There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Although systems were in place which monitored access, patient feedback reflected dissatisfaction regarding access to appointments and access via the telephone system. • The practice commented that improvements had been made in relation to access since the pandemic, there was an ongoing full team effort in improving access and working with patients to make the practice more accessible. The practice had plans to hold future patient engagement events and work with the patient focus group to target feedback for service improvement areas. • During the pandemic, the practice changed the way that patients could access services, such as providing remote video consultation. Home visit appointment triage was available for patients within the local catchment area for those who could not attend the practice and met the criteria. • Vulnerable patients were able to access the service in ways that their needs during the pandemic. For example, with the development of COVID-19 'hot' and 'cold' clinics, logistical clinical areas for patients that presented with or without COVID-19 symptoms. • Provisions for infection control arrangements were in place for staff and patients during the pandemic, for example, personal protective equipment (PPE). 	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The business management team reviewed access data through monthly reports, showing daily capacity and appointments booked by appointment type and categorised by planned (routine) and unplanned (urgent) care. For example, 2,890 GP appointments were available for planned care. Of those, 2,804 GP appointments had been booked in June 2022. For unplanned care for the same time period, there were 3,281 GP appointments available, of which 3,178 GP appointments booked. There was oversight of patient demand to enable leaders to make decisions on staffing cover arrangements.• The practice had not needed to make any statutory notifications to relevant organisations such as the Care Quality Commission (CQC) or National Health Service England (NHSE) within the last 12 months. However, members of the leadership team were aware of their responsibilities to do so if a notification was required.	

Governance and oversight of remote services

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

Explanation of any answers and additional evidence:

- The provider had a registered data controller and data protection officer.
- Patient data and information was stored securely in line with digital security standards with relevant information was made available for patients to access in line with privacy, consent notices and general data protection regulations.
- Information was available for patients on how their data was used, choices regarding consent and how to protect their online data through notices within the practice, practice registration forms or online via the practice website.

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• The practice had implemented a new Human Resource (HR) electronic system which held information about staffing in relation to appraisals and training records. Oversight was held by the newly recruited HR manager. Staff had the opportunity to set performance targets in relation to delivering healthcare services.• Prior to the three practice merger in September 2021, each practice had its own Patient Participation Group (PPG). Due to the COVID-19 pandemic, regular quarterly meetings were suspended due to the provision demands placed on the practices. At the time of inspection, the PPG had not been restarted but the practice was keen to have a broader representation when it did to reflect the needs of its patient population. During this period of time, patient feedback was sought through a pre-merger PPG member who remained on the Fareham Locality Patient Group (FLPG) which gave an opportunity to raise any suggestions to improve the service and any patient safety concerns.• There had been an increasing opportunity for patients to actively engage in proposed changes since the practice merger. For example, invitations to participate in surveys, focus groups and specific topic conversations with key members of the practice team. The practice implemented regular informative patient newsletters, both online and in hard copy, which aim to bridge the 'gap' in patients' knowledge about their practice and its activities.• Improvements had been made in triaging to an appropriate health professional, which resulted in more face-to-face GP appointments available to those who really need that expertise, despite the challenges in patient access.	

Continuous improvement and innovation

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

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

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 practice's 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.