

Care Quality Commission

Inspection Evidence Table

Harris Memorial Surgery

(1-544168690)

Inspection Date: 18 May 2023

Date of data download: 15/05/2023

Overall rating: Inadequate

At the last inspection of this service in 2018 we rated the service as good overall.

At this inspection we have rated the service as inadequate. This was because the Safe and Well Led key questions were rated as inadequate and the effective and responsive key questions were rated as requires improvement. The Caring key question was rated as good.

Safe

Rating: Inadequate

At the last inspection on 13 April 2018, we rated the practice as good for providing safe services. At this inspection, we have rated the service as inadequate for providing safe services because:

- The systems and processes did not protect patients from the risk of abuse. For example, at the time of recruitment and within staff training.
- Health and safety risk assessments had not been completed. There was limited evidence to show risks within the environment and from lone working had been considered.
- Infection prevention and control systems and processes were incomplete. Maintenance was required in some areas to reduce the risk of cross infection.
- Not all actions from the fire risk assessment had been addressed.
- There were delays in summarising new patients records and no system to prioritise those patients at higher risk.
- There were a large number of clinical and administrative tasks outstanding which meant there was a potential risk to patients as important results or issues may not have been addressed.
- There were gaps in the systems and processes to manage medicines.
- There were gaps in the systems to manage significant events.

Safety systems and processes

The practice did not have consistent systems to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	No
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff had access to policies and procedures which provided information and guidance regarding the safeguarding of adults and children. These included information on how to raise concerns. Further information was included on the action to take when a child was not brought to an appointment. • Staff had completed adult and child safeguarding training. The Adult Safeguarding: Roles and Competencies for Health Care Staff August 2018, states that safeguarding vulnerable adults training level 3 should be undertaken by registered health care staff who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns (as appropriate to role). This includes general practitioners and registered nurses. However, the level of training for all staff did not meet national guidelines. For example, practice nurses had completed level 2 training rather than level 3. • The practice had not completed Disclosure and Barring Service (DBS) checks for all clinical and administration staff who worked in the practice, and where there were no DBS checks, the practice had not completed a risk assessment prior to employment. The DBS helps employers make safer recruitment decisions and prevent unsuitable people working with vulnerable people and children. • The patient electronic record system used by the practice provided an alert to staff regarding any safeguarding concerns for individual patients. • Safeguarding concerns were identified and discussed at meetings which were held every six weeks. A safeguarding register was maintained which identified all patients with safeguarding concerns. • The practice liaised with external professionals regarding individual patients where there were concerns. An electronic system was used to alert the out of hours service of specific concerns regarding patients including safeguarding concerns. • Safeguarding vulnerable adult processes had been audited three times within the practice. This was a local audit and the information shared with the practice team. As part of those audits learning in how to manage clear coding, and job descriptions for safeguarding roles had been clarified. As a result of that audit there was an ongoing action plan which we reviewed. 	
Recruitment systems	Y/N/Partial

Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Staff files did not provide evidence of staff vaccination and immunity to health related diseases. We requested this information and were told this was contained in personnel folders. Of the five folders reviewed we saw one member of staffs' immunity status to Hepatitis B (a disease of the liver that can be transferred through bodily fluids) recorded. We asked during the inspection for this information and were not provided with any additional detail. This does not comply with national guidance set out by the Department of Health. The documentation did not include all information required to meet Regulation 19 and Schedule 3 of the Health and Social Care Act. We reviewed the personnel folders of 4 members of staff. The recruitment records did not evidence that a consistent approach was followed when recruiting staff. For example: <ol style="list-style-type: none"> Staff member 1 –The recruitment records did not demonstrate the persons health and fitness to carry out their role had been considered. There had been no DBS check or risk assessment completed prior to the person commencing work at the practice. Staff member 3 - there was no evidence of their professional registration with the Nursing and Midwifery Council at the time of appointment (although this was printed off the website during the inspection), no assessment of their health or vaccination history and no DBS check was available. Staff member 4 – one reference was not signed or dated, information relating to their vaccination status of Hepatitis B only, no health assessment and no DBS check carried out by the current employer was available. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Partial
Date of last assessment: 15 July 2019	No
There was a fire procedure.	Yes
Date of fire risk assessment: 24 March 2023	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> A fire risk assessment had been completed on 24 March 2023 by a member of staff. This had not identified any recommendations or concerns. The member of staff had not received any formal training or guidance regarding completing fire risk assessments. The fire safety policy did not reflect the facilities in the branch surgery for example, the fire risk assessment did not reference the storage of medical oxygen. There was a weekly fire alarm test carried out which had last been done on 15 May 2023. Fire drills were planned but not regularly completed. There were two allocated fire Marshalls who had not received any training for the role. Checks to the fire prevention systems were carried out by an external company. The most recent checks had occurred on the 30 January 2023. The associated report recommended that the fire panel was obsolete and needed relocating to meet national standards. There were recommendations made in the report which had not been addressed. We discussed this with the provider who was unable to provide an 	

action plan and commented these were recommendations and not requirements and gave no indication of completion timescales.

- The most recent check of fire extinguishers had been completed on 12 May 2023.
- The health and safety risk assessment which had been completed in 2019 gave an overview of the safety standards expected. For example, walkways would remain unobstructed and portable appliance testing would take place visually and at six monthly intervals. However, there was no audit or checklist to demonstrate the premises had been risk assessed for the health and safety of patients and staff.
- The practice did not maintain a risk register to provide information on identified risks and the mitigating action taken.
- The business manager told us they held a maintenance list but was unable to access this on the day of the inspection. Following the inspection, we received a list of works that were required to be completed to ensure the safety and suitability of the premises for the running of the service. However, this did not provide information on action that would be taken to address all of the required works and improvements. For example, areas of maintenance had been identified as being required both internally and externally but there were no dates for completion or actions taken to address recorded. There was information relating to worn flooring and electrical works required which indicated external organisations had been booked to address these issues.
- All medical equipment had been serviced. There was no action plan associated to the service register. We identified three pieces of medical equipment had failed the service, but management staff were unable to confirm what had happened to the equipment. We were later told that the equipment had been disposed of.
- Portable appliance testing was arranged and overseen by the practice manager and records were held to evidence the testing by an external organisation.
- Not all areas of the practice were managed safely. A stock cupboard, which contained nursing equipment, was maintained on the corridor opposite a waiting chair. Throughout the morning we saw patients sitting on this chair with the cupboard unlocked in front of them. This provided a risk that stock could be tampered with.
- The phlebotomy room had no privacy curtain for patients using the couch. This meant the privacy of patients could have been compromised should another person enter the room during their consultation. There were no signs on the door to indicate if the room was in use.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	No
Infection prevention and control audits were carried out.	No
Date of last infection prevention and control audit: Not completed	No
The practice had acted on any issues identified in infection prevention and control audits.	No
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence:	

- The lead nurse held the role infection prevention and control (IPC) lead. Their name was recorded within the IPC handbook so that staff knew who to approach for additional support and/or guidance. There had been no additional training undertaken for this role and no systems implemented to raise issues and share learning with staff. Staff were able to access IPC training online. However, the training information we were shown did not demonstrate that all staff had completed this training.
- A hand hygiene audit had been completed in March 2023 and actions had been taken as a result and included changing waste bins to foot operated bins to reduce the risk from cross infection.
- A full IPC audit had not been completed. There were areas of the service which required improvement which may have been identified had an audit been completed.
- There were concerns identified within the premises which meant infection prevention and control was compromised due to areas not being able to be cleaned thoroughly. There were signs of wear and tear associated with the buildings use. For example, there were some holes in the reception wall created by the removal of hand gel dispensers and peeling paint in the waiting room. We saw areas of the environment where the flooring was damaged. For example, the practice nurse clinical room, the phlebotomy room and the waiting room. The waiting room had a raised area of flooring without any warning notices for patients. The phlebotomy room wall was damaged, the filing cabinet was very rusty and the sink unit did not have a smooth and easy to clean surface.
- We were told part of the environmental overview was to fill holes in the walls. There were no timescales provided for completion of this.
- The practice manager was aware there was furniture in the communal waiting area which required repair/replacement but was unaware of the action or timescales in progress to address this issue.
- The practice manager maintained information sheets and data regarding cleaning materials and other chemicals or substances hazardous to health (COSHH) and cleaning equipment and solutions were stored away from public areas.
- Hand gel was available throughout the premises and accessible to patients and staff.
- There was an annual legionella test performed, last carried out in March 2023. We were told staff used to flush the water outlets each week to reduce the risk from the presence of legionella, but we were unable to see records for this as they had not been kept. This process had stopped some time ago based on advice given. However, this does not protect patients and staff and did not ensure the risk was a managed risk.
- We observed two patients were brought to the practice with a confirmed infectious disease. We did not see any additional cleaning was carried out of the areas they used.
- A cleaner was employed by the practice who attended the practice each weekday for cleaning both clinical and non-clinical areas. The premises looked clean and tidy. A cleaning schedule was available to staff. We requested cleaning audits but these had not been completed.
- Clinical waste storage was available in clinical rooms. Sharps' boxes were dated and signed when first in use and again when ready for disposal, this enabled an audit trail of their use. Storage of clinical waste was held securely until collected.

Risks to patients

There were not systems to consistently assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
There was an effective induction system for temporary staff tailored to their role.	Partial
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Staffing levels were planned to ensure there was enough cover for periods of leave such as annual leave or to cover sickness. However, there were shortages in nursing and medical staff which impacted on the services provided and the monitoring of the service. Staffing vacancies included – 1 GP, with 1 GP in the process of being recruited and 1 nurse vacancy. At the time of the inspection there were insufficient staff to fulfil demand from patients. Patients unable to access an appointment due to the lack of availability were referred to walk in urgent care centre. However, there was no audit completed to identify how many patients had been sent there and to measure the overall demand for the service. The lead GP partner was not always recorded on the rota to ensure an accurate reflection of the demand on the service. For example, we were told they worked in practice until 8pm/9pm most nights so therefore provided support to the HCA on late night opening. However, this could not be evidenced on the staff rotas. During our inspection the lead GP had removed themselves from the rota to support the inspection and we were told after the inspection that a remote locum had been arranged to provide support.. Not all staff were provided with induction training to support them to work safely. We saw an induction checklist had been completed for newly appointed reception and administration staff. We were told newly recruited clinicians were provided with shadowing opportunities (spending time with experienced staff) prior to working alone. However, we asked for but did not receive evidence which supported this process. Not all systems supported patient safety. There was a blood pressure machine in reception for patients to use. Blood pressure results were printed out from the machine and patients handed them in at reception. Staff had no training and no access to a policy to indicate which levels of blood pressure were of concern and when the doctor should be informed. Staff said they would often ask for best of three results and then take advice from the doctor. Reception staff did not receive any formalised recorded training to support decision-making about patients. We were told reception staff are trained by more experienced reception and care navigator staff. However they had immediate access to a GP (between 8am and 10am) if they had concerns about the wellbeing of patients waiting in reception or on a telephone call. Reception staff had received basic life support training, which included sepsis management. They confirmed they would ask the GP for advice if they had any concerns about patient safety. The reception area held 	

information for staff to reference including a sepsis support tool. They could also access some information on the computer to support their decision making.

- Reception staff told us they would refer patients presenting with head injuries to the local walk in urgent care centre and those with significant medical need to telephone the emergency NHS ambulance service.
- The emergency equipment was stored in two bags. One bag held two oxygen cylinders and associated equipment (last checked 12 May 2023). There was appropriate oxygen signage on the room door. The second bag had emergency equipment and emergency medicines. A defibrillator was also held with the equipment and that was last serviced in February 2023. A record was maintained of the weekly checks of emergency equipment to ensure that if needed urgently the equipment was available and in good working order.
- Emergency medicines were held within the emergency bag included medicines used to treat chest pain, a stroke and low blood sugar. A medicines box was also available to treat anaphylaxis. (Anaphylaxis is a severe, potentially life-threatening allergic reaction that can develop rapidly)

Information to deliver safe care and treatment

Staff did not consistently have the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Partial
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The system for processing information relating to new patients and the summarisation of their records was inconsistently managed. Patients' existing notes were stored in an office while waiting for summarisation. When received into the practice the notes were recorded on a spreadsheet. However, the system and/or the spreadsheet did not identify vulnerable patients or those at risk who should be prioritised for the summarisation of their records. This was a potential risk if a clinician was required to access this information. However, we were told that if a patient's records were needed by the doctor, they would be found and summarised immediately to enable the doctor to access the information. The 	

practice could not identify how long the records had been waiting for summarisation as this was not recorded on the spreadsheet.

- We saw there were a large number of documents, relating to patient information, waiting to be scanned and filed into patients' clinical records. This meant that important information could be missed by clinicians providing care and treatment to patients. The provider informed us following the inspection that additional staff support was to be allocated to this workflow to reduce the number of records waiting to be processed.
- Referral guidelines were available to staff within a policy format. The guidelines included information on 2 week wait referrals to secondary care and referrals to children's mental health services. Referral processes were well documented to enable staff to follow the correct process.
- Referrals were made by clinical staff and typed and sent out by the administration staff.
- The practice had a system to manage the receipt of test results to ensure clinical oversight of the tests. The process detailed that if a temporary clinician had requested the tests the results were allocated to the patients named GP to ensure results were seen and actioned.

Appropriate and safe use of medicines

The practice did not have consistently followed 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)	0.75	0.88	0.86	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2022 to 31/12/2022) (NHSBSA)	11.1%	8.5%	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)	4.81	5.28	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	192.5‰	154.3‰	130.3‰	No statistical variation
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)	0.37	0.61	0.56	No statistical variation

Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) <small>(NHSBSA)</small>	8.8‰	7.0‰	6.8‰	No statistical variation
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Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	No
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Partial
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> We carried out remote searches of patients' clinical records on Tuesday 16 May 2023. The searches were completed by a GP specialist advisor (SPA) who was satisfied there was an ongoing process and system to provide monitoring to patients who were on medicines which required additional tests. The clinical records reviewed showed appropriate narrative and monitoring of the patient. 	

- The clinical searches identified a total of 840 patients taking a medicine or group of medicines used to treat high blood pressure, heart and kidney problems. Of the 840, we identified 22 patients who appeared to be overdue appropriate monitoring. Out of these 22 patients, we sampled the clinical records for 5 of these patients and found only 1 out of the 5 patients had not had the required monitoring. This patient had been recalled for monitoring by the practice, but had not attended.
- The clinical searches identified a total of 142 patients taking a medicine or group of medicines which may be used to treat neuropathic pain. Of these we identified 38 patients who appeared to be overdue appropriate monitoring. The practice agreed to review each patient and provide further information on the action taken. We requested this information a further time after the inspection but have not received any additional assurances.
- The practice used electronic messaging to send 'tasks' to clinicians. During a review of the practice clinical records system, the SPA identified there were a number of outstanding tasks for clinicians. Following discussion with the registered manager, it was identified there were 124 tasks outstanding with some dated March 2023. Some of these had been reviewed and actioned but not closed. A number of the tasks were for the pharmacist, some for the midwife and a significant number regarding blood test monitoring results for a nurse who had left the practice. This identified a potential risk to patients as important results or issues may not have been addressed. The registered manager agreed to review all tasks and report back to us. We received information shortly after the inspection which demonstrated that this issue had been discussed at a clinical meeting and action taken to reduce the tasks which were outstanding. Actions had been taken to reduce the risk of tasks being allocated to staff who no longer worked at the practice.
- There was no evidence to demonstrate the prescribing by non-medical prescribers remained within competence. The provider advised there was a process to review the non-medical prescribers practice supported by clinical supervision or peer review. However, we requested evidence to support this before and during the inspection, but the provider was unable to provide this.
- Patient Group Directions (PGDs) were used for nurses to administer some medicines and these had been signed and were up to date. PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber such as a GP or nurse prescriber.
- Information relating to controlled drugs is included in the dispensary services part of the report below.

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Yes
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Partial
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Yes
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Yes

Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Partial
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Yes
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Partial
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	No
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Yes
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes
<p>Explanation of any answers and other comments on dispensary services</p> <ul style="list-style-type: none"> Standard Operating Procedures (SOP) covered most aspects of the dispensing process and were regularly reviewed, read and signed by staff. However, there was no standard operating procedure or risk assessment for the delivery service, or for dispensing into Monitored Dose Systems (MDS). Where MDS dispensing took place staff had no written guidance on how to identify medicines not suitable for inclusion, and no recorded audit trail for the dispensing and checking of these packs. There was no system for giving patient information leaflets with these packs. These systems were not available to ensure patients medicines were managed safely. The delivery service had no SOP (apart from controlled drug delivery) or risk assessment, and confidentiality of patient information was not managed securely. Medicines were dispensed and delivered inside sealed bags. Information relating to the patient and the medicines were identifiable on the outside of the bag. Since the inspection, the provider advised us that information relating to the medicines prescribed to patients has been removed from the outside of the sealed bag and a new CD delivery policy and procedure has been implemented. Most medicine stocks were stored and recorded appropriately. However, improvements were needed for Controlled Drug (CD) recording and disposal arrangements. There were expired stock items which had been waiting disposal since 2018. The SOP regarding systems and processes for managing controlled drugs identified there should be monthly stock checks. However, the last recorded stock check in the CD register was dated 19 October 2021. Since the inspection the provider advised us that the practice had obtained a waste exemption certificate to dispose of expired stock and that CD stock checks had been restarted. The SOP had been updated to provide guidance to staff on completing CD checks every 2 months. 	

Track record on safety and lessons learned and improvements made

The practice mostly learned and made improvements when things went wrong.

Significant events	Y/N/Partial
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The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	4
Number of events that required action:	4
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There were gaps in the system to manage significant events. We were told the 4 significant events we reviewed were discussed at the clinical meetings and actions had been agreed to address the incident to reduce the risk of reoccurrence. However, the clinical meeting minutes we were shown did not evidence this and no other record could be found to demonstrate the actions taken were recorded and followed up. The lead GP recognised that an improved process was required in order to provide an audit trail of the learning and actions taken. • Further information from the practice advised that in addition to the 4 significant events detailed there had been a 'number' of significant events linked to diagnosis of cancer outside of the 2 week wait referral system. This was highlighted as part of engagement with an external organisation initiative to improve early cancer diagnosis. 	

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

Event	Specific action taken
The significant event involved the incorrect prescribing of diamorphine for a patient receiving end of life care for pain relief. An error in calculation meant the patient received too high a dose.	<p>Duty of Candour was used to inform the family of the outcome of the investigation and controlled drugs accountable officer for the area notified.</p> <p>Appropriate notifications were made to NHS England, CQC were notified and the safeguarding lead at the local authority.</p> <p>Learning points were identified and a report completed with action timescales.</p>
The significant event referred to a patient who had an unplanned pregnancy whilst taking a medicine that could be a risk during pregnancy. The incident had been investigated to establish if sufficient pregnancy planning and information had been provided and a report written.	The provider was unable to provide evidence of how this incident had been reviewed and discussed with the clinical team to share any learning.
This event noted a child who should have been under the care of the children's mental health system but due to travelling was lost from the system.	Subsequently medication required to treat the child's mental health condition had not been prescribed.

	The incident was investigated, reported and then actions taken forward for all involved.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Staff confirmed they received information by email regarding safety alerts. However, there was confusion within the practice regarding who had responsibility for checking alerts and sharing information within the staff team. For example, management staff and clinical staff provided different views on how the alerts were shared. • MHRA alerts were discussed at the clinical team meetings each Wednesday. However, the minutes of these meetings were brief and it was not clear from the minutes of the discussions if any actions were taken. We were provided with minutes of a clinical meeting held after the inspection which evidenced the process of actioning and sharing safety alerts within the practice had been reviewed and developed. • Our review of patient records in relation to the clinical searches did not highlight any concerns of action taken in order to comply with MHRA alerts. However, the practice had identified a significant event (see above) which had identified a previous MHRA alert had not been followed. This was regarding ensuring that women of child-bearing age were provided with sufficient information to make an informed choice prior to being prescribed certain medicines. 	

Effective

Rating: Requires improvement

At the last inspection in April 2018 we rated the practice as good for providing effective services.

At this inspection, we found while the provider had maintained some areas of good practice, there were gaps in the systems and processes to provide an effective service. The practice is therefore now rated requires improvement for providing effective services because:

- Not all staff had received training to ensure they were skilled and competent when triaging patients.
- The numbers of cervical screening carried out in the practice had not met national targets.
- There was limited involvement in local and national quality improvement initiatives or clinical auditing.
- There was limited evidence to demonstrate staff received induction training when new in post or in temporary positions and that time was provided to formally meet with their line managers for supervision, one to ones or coaching sessions.
- Not all patients had access to health checks.

Quality and Outcome Framework (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 mostly 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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Partial
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Yes
The practice prioritised care for their most clinically vulnerable patients.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Access to care and treatment decisions were sometimes made by untrained staff. We were told prior to the inspection, and we observed when on site, that non-clinical staff (staff who were experienced receptionists, now known within the practice as care navigators) triaged patients. There was no evidence to demonstrate they had been provided with formal training or guidelines to support this role to ensure patients were provided with appropriate appointments/guidance. However, the care navigators were provided with support by a duty GP each day between 8am to 10am where they could refer queries immediately. At other times if there was a query regarding a patient, they told us they would seek advice from a clinician. We were told care navigators made decisions about how urgent an appointment is required. For example, if a patient required an urgent appointment, if they could wait up to two weeks for a routine appointment or be sign posted to the local walk-in urgent care centre We observed two patients were prioritised due to their assessed need on the day and were provided with immediate appointments with the paramedic. • The practice employs an elder care matron whose role included providing care and treatment to older and frail patients. They completed assessments, carried out home visits and were a nurse prescriber which meant they could see and treat patients immediately. 	

Effective care for the practice population

Findings

- Those identified received a full assessment of their physical, mental and social needs. The practice employed a social prescriber who identified and supported patients with additional needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age. An elder care matron completed home visits and offered support to older/frail patients.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to some health assessments and checks, but this did not consistently include NHS checks for patients aged 40 to 74. Systems were not in place to support recalls for these health checks and the nursing staff provided the checks opportunistically. For example, if the patient attended a clinic for another reason. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. For example, diabetes and asthma checks.
- 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. For example, when planning covid and flu vaccinations.
- 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

- We reviewed a random sample of patient records and found that the patients had had reviews for their long-term conditions. Staff who completed long-term condition reviews had received training to support them with this process.
- 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.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. Following the inspection, we were provided with minutes from a clinical meeting which demonstrated the practice had implemented a new protocol to ensure all patients with blood results relating to their diabetes were followed up promptly.
- 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 influenzae 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)	69	70	98.6%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	62	69	89.9%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	63	69	91.3%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	63	69	91.3%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	61	66	92.4%	Met 90% minimum

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

Any additional evidence or comments
The practice contacted parents and carers of children who were due a vaccination to encourage them to attend. Children who were not brought to appointments were followed up with contact made with their parent or carers.

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)	60.4%	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)	70.1%	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). (31/12/2022 to 31/12/2022) <small>(UKHSA)</small>	70.7%	N/A	80.0%	Below 80% target
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Any additional evidence or comments

- The data shown above identified the practice's uptake for cervical screening was not meeting national target. There was confusion around cervical screening being provided at times to meet the needs of working women, for example on alternate Saturdays. The practice manager and provider stated these appointments were available. However, nursing staff told us they did not provide cervical screening at the weekends as the specimens could not be collected until the following week. Following the inspection, the practice advised us that action had been taken to provide clarity to staff.
- We requested additional information regarding the action plan to increase cervical screening and the trajectory to indicate if the national target would be met this year. This information was not provided to us.

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	No
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ul style="list-style-type: none"> • There was limited involvement in local and national quality improvement initiatives or clinical auditing. • There had been a programme of auditing contraceptive service. The last audit had taken place in 2019 and it was recognised this required updating. • The safeguarding audit had resulted in changes in coding to make patients with associated safeguarding concerns known to all staff who accessed their records. • The practice employed a pharmacist who completed workflow and medicine audits and held an annual audit overview to ensure routine and regular audits were completed for all identified areas. The audits carried out by the pharmacist included a lithium audit in January 2023 which showed three patients were prescribed lithium, two were within parameters and one was encouraged to contact the surgery. All patients of childbearing age prescribed sodium valproate were reviewed in January and May 2023. No issues were found. • Feedback from the pharmacy audits was provided to the clinical team. The most recent feedback provided was in February 2023 regarding an antibiotic audit. This meant learning was shared with all clinicians. 	

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Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Partial
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Partial
There was an induction programme for new staff.	Partial
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Not all staff received a period of induction training. For example, there was no evidence to support that locum staff or nursing staff had received induction training. However, for administration and reception staff there were completed induction checklists held on their personnel files. • Staff were enabled to complete mandatory training as over time and were paid for these additional hours. The provider planned to look at the provision of protected time within the rotas for staff to complete their training in working hours. • Staff were supported to attend role specific training and allocated time during their working day to attend external courses. • Records evidenced that annual appraisals were completed. Staff were not provided with formal supervision sessions with their line managers but confirmed they felt supported in their roles. They told us they were always able to speak with managers at the practice. • We were told the nursing team received support to complete their planned revalidation with the Nursing and Midwifery Council. However, there were no records to show the nurses were up to date with their revalidation. • Not all staff had been provided with training regarding how to manage challenging patients. The provider told us the senior team had provided support to junior staff regarding appropriate response to challenging patients. 	

Coordinating care and treatment

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

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

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Partial
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice website provided information on health lifestyles.• Guidance and information was available, together with links to relevant external organisations on health conditions, including long-term conditions.• However, patients were not able to consistently access appropriate health checks as the practice did not currently provide health checks for patients aged 40-74.	

Consent to care and treatment

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

	Y/N/Partial
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Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. 1	Yes
<p>Explanation of any answers and additional evidence</p> <ul style="list-style-type: none"> The GPs used opportunities as they presented, to ensure that Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) were completed. These agreements of care were reviewed as necessary to ensure the correct legal pathways were created to support patient choice. All treatment escalation plans were signed by the patient's GP, and their views were included. For patients diagnosed with cancer, their care and treatment was discussed at a six weekly multi-disciplinary meeting. The treatment escalation plans and DNACPR decisions formed part of this discussion. Staff understood Gillick competence and provided examples of when this would be followed. (Children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. This is known as being Gillick competent. Otherwise, someone with parental responsibility can consent for them). 	

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

Patient feedback	
Source	Feedback
Three Patients had contacted the Care Quality Commission within the last 12 months	The patients raised concerns about access to the practice, in particular about being unable to make an appointment and arranged telephone consultations were not received.

NHS UK website within the last 12 months	One patient left a positive review regarding their care and treatment whilst another patient left a negative review regarding accessing appointments and not being able to get through on the telephone.
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National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	82.7%	88.0%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	84.9%	87.9%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	88.6%	94.7%	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)	71.3%	78.6%	72.4%	No statistical variation

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

Any additional evidence

- The practice encouraged patients to complete short surveys to identify the satisfaction of the service provided. However, these were not reviewed by the practice to identify themes or trends for improvement.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes

Staff helped patients and their carers find further information and access community and advocacy services.	Yes
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Source	Feedback
Interviews with patients.	We spoke with two patients who were happy with the care and treatment they received.

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)	89.8%	92.1%	89.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	6 young carers under the age of 18 20 carers over the age of 18 The percentage of carers identified from the practice patient list is 0.42%. This is below the national average for similar sized practices.
How the practice supported carers (including young carers).	The social prescriber provided support to carers and could signpost them to relevant organisations. The practice invited carers to attend the practice as part of the ongoing vaccination programme. For example, for flu and covid vaccines. The elder care matron provided support and information to carers of patients they provided care and treatment to.
How the practice supported recently bereaved patients.	The practice sends a condolences card to recently bereaved patients and offers the opportunity for a telephone conversation or a face to face appointment should they wish to ask any questions or discuss their recent loss. Details are also provided of external organisations who provide support to recently bereaved people.

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Privacy and dignity

The practice did not always respect patients’ privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	No
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was a lack of confidentiality and privacy when patients were speaking to the reception staff at the front desk. Conversations could be clearly heard by people entering the reception area. However, once patients were in the waiting room measures had been taken so conversations at the desk would not be heard in the waiting room. 	

Responsive

Rating: Requires improvement

At the last inspection in April 2018, we rated the practice as good for providing responsive services. At this inspection, we found while the provider had maintained some areas of good practice, there were gaps in their ability to provide a responsive service due to the identified issues with access to appointments.

We rated the practice as requires improvement because:

- Issues were identified concerning access to the practice and to appointments with GPs.
- The process for managing complaints was inconsistent.

Responding to and meeting people’s needs

The practice organised and delivered services to meet patients’ needs

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

Explanation of any answers and additional evidence:

- The provider met the needs of the local population.
- The practice had recognised the aging profile of their patient cohort and had appointed a community matron to join the clinical team as an 'eldercare Matron' who led on the care of older patients and complex care within the practice. This role provided support to local care homes and housebound patients
- The practice provided health care to asylum seekers who lived locally. They worked together with an external organisation who oversaw services for asylum seekers and were able to support the practice with interpreters and translation.
- The practice was knowledgeable about services for homeless people and travelers and stated these groups of people would not be registered with the practice as they do not register temporary patients. There was a GP service located nearby who provided services to people with no fixed abode. However, the provider worked with an external organisation to support referrals to secondary care for homeless people.

Practice Opening Times – Harris Memorial Surgery

Day	Time
Opening times:	
Monday	8am – 6pm
Tuesday	8am – 6pm
Wednesday	8am – 7.15pm
Thursday	8am - 6pm
Friday	8am -6pm
Appointments available:	
Monday	8am - 6pm
Tuesday	8am -6pm
Wednesday	8am – 7.15pm nurse appointments only after 6pm
Thursday	8am – 6pm
Friday	8am – 6pm

Practice Opening Times – Lanner Surgery

Day	Time
Opening times:	
Monday	9am – 1pm
Tuesday	10am – 12noon
Wednesday	10am – 12noon

Thursday	10am – 12noon
Friday	10am -12noon 2pm – 3.30pm
Appointments available:	
Monday	9am – 1pm
Tuesday	10am – 12noon
Wednesday	10am – 12noon
Thursday	10am – 12noon
Friday	10am -12noon 2pm – 3.30pm

Access to the service

People were not 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.	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes
Patients were able to make appointments in a way which met their needs.	No
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised.	Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> There had been concerns identified regarding access to the practice by telephone. The practice had taken action to address this by installing a new telephone system. An electronic screen had been installed as part of the new system which enabled data to be collated to audit the telephone system. However, the data provided by the system had not been used to establish if the service being provided was responsive to patient's needs. The practice reviewed the number of callers waiting and additional staff could be called upon to answer the telephone if necessary. At 11am on the day of inspection, the board showed six inbound calls had been abandoned while 26 calls had been answered. There was no data used to identify if the numbers of calls were higher at any given time and so staffing could be adjusted to meet demand. 	

- When patients called the practice, they could choose if they required nurse or GP support. The call was then diverted to reception staff for the nurse appointments and staff known as care navigators for GP appointments. The care navigators were provided with support by a duty GP each day 8am-10am where they could refer queries immediately. At other times if there was a query regarding a patient they would seek advice from any available clinician. A duty doctor was not allocated to be available. However, there were no written guidelines or algorithms for care coordinators to follow to ensure patients were provided with appropriate appointments/guidance. We were told care navigators made decisions about how the urgency for an appointment and whether an immediate or routine appointment is required.
- There were insufficient appointments to see patients and staff told us patients were signposted to the local walk in urgent care centre. On the day of inspection at 11 am there were limited appointments available. The lead GP had 5 telephone consultations left and no face to face appointments available. The locum GP had 1 face to face appointment and 2 telephone consultation appointments left. The paramedic had 6 face to face appointments left and 14 telephone appointments left. We saw 2 of the paramedic appointments were filled with patients who attended the practice to seek medical help.
- During the inspection, at 3pm, we observed that on Friday 19 May 2023 there was only 1 face to face GP appointment and no appointments for telephone consultations available and on Monday 22 May 2023 only 6 face to face appointments and 13 telephone triage calls were available. This meant there was a risk that not all patients would be able to see a clinician on these days. The reception staff told us they recognised this was stressful to manage and had raised their concerns with the practice manager and lead GP. They felt there was more flexibility with appointments to enable patients to be booked in now that they had access to the paramedic.
- When reviewing the complaints, a patient had reported they requested an appointment on the 8 August 2022 but was told the first appointment would be in September 2022. They were subsequently advised to attend the MIU. There was no information relating to any investigation or follow up to review the circumstances of this delay in appointment.
- Alternate Saturday morning clinics were held with the lead GP. This was not on the notice outside of surgery to inform patients of this service.
- During the inspection we observed 1 patient had been waiting 25 minutes to be seen by the doctor and due to other commitments could not wait any longer so left the practice without being seen.

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)	57.8%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall	51.2%	63.8%	56.2%	No statistical variation

experience of making an appointment (01/01/2022 to 30/04/2022)				
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)	52.1%	62.1%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	70.6%	78.0%	71.9%	No statistical variation

Source	Feedback
NHS.uk website (formerly NHS Choices)	In the last year there had been two negative comments left on the NHS.uk website regarding the practice. These both related to having difficulties accessing the practice by telephone, a lack of appointments meaning the person had been redirected to the local walk in urgent care centre and attitudes of staff. The practice had not responded to these comments on the website.

Listening and learning from concerns and complaints

Complaints were not consistently used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	14
Number of complaints we examined.	5
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.	1

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The process to manage complaints had not been followed consistently. Paper and electronic documentation relating to complaints did not always evidence the action taken, learning shared or changes to practice. Not all complaints were dated or signed by the person receiving and investigating the issues raised. Therefore, we were unable to evidence the complainant had been responded to in a timely way. Other complaints were detailed and contained all written information. Complaints were not formally audited or reviewed for themes or patterns. Out of the 5 complaints we reviewed, the records showed 3 complainants had received a response within the timescales detailed in the complaints policy. The other records did not contain sufficient information to demonstrate this. 	

- The practice manager provided us with examples of when people’s complaints or concerns were responded to immediately but there was no evidence retained to support this. This did not provide the practice with information to review or audit to identify themes or trends and improve practice.

Example(s) of learning from complaints.

Complaint	Specific action taken
One patient complained there had been limited contact or support following bereavement	The practice had contacted the patient and a system implemented in which all bereaved patients now receive contact and a sympathy card from the practice.

Well-led

Rating: Inadequate

At the last inspection in April 2018 we rated the practice as good for providing well led services. At this inspection we rated the practice inadequate because:

- We found that while the provider had maintained some areas of good practice, there were gaps in the governance systems and processes to provide a well led service.
- Leaders had not always completed management training and/or qualifications.
- The vision and values of the practice had not been developed with staff and staff were not aware of these.
- There were not clear and effective processes for the oversight and management of risk. For example, security of the building and lone working.

Leadership capacity and capability

There was compassionate leadership at all levels but leaders could not demonstrate 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.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Partial

Explanation of any answers and additional evidence:

- Staff spoke positively of the support they received from their line managers, the practice manager and the GPs.
- Staff appointed into management or leadership roles had not completed appropriate management training and qualifications. This meant they did not always have the insight or support to be effective. There was no evidence to support managers had been provided with formal relevant or recent management training.
- Staff were allocated leadership roles which included infection prevention and control and safeguarding. However, these roles were not reviewed to identify training needs or improve and develop the service.
- Support for managers was sought from external stakeholders, such as the local integrated care board, when the practice manager was new in post. The practice manager was able to access a local practice manager forum for support and information.
- The rota did not clearly identify when managers and the lead GP were available to staff. For example, we were told the lead GP worked in the practice, completing management tasks, until 8pm most evenings. In addition, during working hours, the lead GP had management time allocated but this role was not clearly shown on the rota.

Vision and strategy

The practice did not have clear visions and values, supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	No
Staff knew and understood the vision, values and strategy and their role in achieving them.	No
Progress against delivery of the strategy was monitored.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We requested information regarding the vision and values of the practice both before and during the inspection. We were provided with a brief written statement on what the vision of Harris Memorial Surgery was planned to be. There was no evidence of how the vision and values had been developed or the involvement of staff and patients within this. 	

Culture

The practice culture did not effectively support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Partial
There were systems to ensure compliance with the requirements of the duty of candour.	Partial
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Partial
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	No
Staff had undertaken equality and diversity training.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Staff spoke positively of working at the practice and the support they received from their managers and colleagues. However, we were told there were times when the practice was busy and short-staffed due to sickness or leave. At these times the staff provided cover for each other which often meant working additional hours and leaving their main role uncovered. We were told staff did not have access to a Freedom to Speak Up Guardian should they wish to raise any issues to an impartial person. We saw example of when the duty of candour legislation had been followed within the complaints records. However, through discussion it was evidenced there was a lack of understanding from some staff regarding the duty of candour legislation and the processes that are required to comply with the regulations. 	

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

Source	Feedback
Staff interviews prior to the inspection	We spoke with four members of staff prior to the inspection. Staff were positive about the support they received from their colleagues and from their line managers. They said they were able to approach any member of staff for advice and support when needed.
Information received prior to the inspection	We received information of concern prior to the inspection. This was about staffing levels, the management of the service and staff feeling unable to raise their concerns.
Discussion with staff during the inspection.	Staff told us they felt supported by the management of the service and able to raise any issues with the practice manager.
Care Quality Commission staff surveys sent to staff prior to the inspection	We received two completed questionnaires which contained positive comments. The comments included staff felt supported, there were enough staff for them to carry out their role and locum cover was arranged when necessary.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice did not have any regular governance systems to monitor the quality of their service, with the exception of medicines management and associated audits carried out by the pharmacist. There were no programmes of continuous clinical assessment and internal auditing to monitor quality and to make improvements. • Assurance systems did not monitor the services provided. For example, there was no auditing of clinical practices or administrative services to ensure they were safe and well led. • For example, there was a lack of systems and processes to ensure effective monitoring of records. The governance process to provide oversight of summarisation of patients did not prioritise the summarisation of records relating to vulnerable patients. • There was limited overview maintained to ensure clinical targets were met. Cervical screening uptake was not meeting the national target. There was no clear plan of how the practice was going to increase the rates of cervical screening. For example, how the practice intended to encourage patients to attend for screening or additional appointments at various times for working women to attend. We were told additional clinics had been set up at the weekend during which cervical screening could be carried out. However, we were also told that cervical screening was not carried out at the weekend as the samples would not be collected until the following week. Since the inspection we have been provided with additional information demonstrating how staff have been updated regarding the provision of cervical screening at weekends. • Some staff had been given extra roles and tasks in addition to their established role. The process of role enhancement and effectiveness of the role were not reviewed and audited to ensure they were successful. We were told limited information had been provided regarding the additional roles. The job descriptions were not consistently changed to reflect additional roles allocated to staff members. Contract changes were identified and a new contract issued and signed by the staff member. For example when hours or specific role changed • There was a lack of oversight for the recruitment systems and processes. Depending on the role of the applicant different staff were involved in the recruitment and interviewing of the applicant. This meant information relating to the recruitment was not consistently collated and contained in the personnel folders. For example, one member of staff said they would have made notes during, an interview but these would have been destroyed afterwards. 	

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	No
When considering service developments or changes, the impact on quality and sustainability was assessed.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a business continuity plan in place to provide advice and guidance to staff to avoid disruption to the running of the practice. • Oversight of arrangements for identifying, managing and mitigating risks was poor. Not all risks were not consistently considered and assessed fully to ensure actions were undertaken to reduce any risks to patients and staff. This had led to gaps in risk management, for example, environmental and maintenance risks, infection prevention and control risks and fire risks. In addition, the security systems at the practice did not ensure the safety and security of the building. There was a lack of oversight regarding the security of the building and contents due to all keys stored in a central location which all staff had access to. This included the key to the office in which confidential records relating to staff personnel folders and the business financial information. The key to the filing cabinets containing this information was in not held securely. The provider and practice manager provided assurances that this would be addressed immediately. • There was a lack of oversight of the risks from lone working. Staff unlocked the building in the morning and secured it at night alone. There had been no consideration to the risks of staff securing or unlocking the building alone. • However, following the inspection the provider was able to appraise us of areas where quality review had taken place. For example, GP oversight of care navigation had been brought in earlier in 2023 in view of identified risks and issues that needed to be managed. However, this had not been formally monitored to demonstrate improvements. 	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> ○ There were limited systems to identify or gather information/data about performance of the practice and no processes to then address any identified issues. For example, there was no data gathered to 	

identify patients sent to other care centers for example MIU when they had not been able to access their GP service.

- Data was not gathered or used to consider or improve the service provided. For example, the practice did not monitor patient telephone calls for response and waiting times to establish if there were any delays.

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.	Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Staff are supported to work remotely where applicable.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Computers and electronic systems were password protected and accessed with smart cards. However, during the inspection we observed a member of staff leave a clinical room without securing the room during their clinic appointments. The computer had not been locked and was accessible. • We were concerned of an incident which potentially breached confidentiality in a shared office. Clinicians were discussing patient sensitive information and a telephone was left without being put on hold while another clinician left the room. The sensitive conversation could have been heard by the caller on the telephone. We informed the staff of this matter and they ensured the mute button was activated. 	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes

Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a clinical meeting held each week during which information was shared and staff views discussed. The GPs, nurse lead and pharmacist attended these meetings. • The nurses, reception and administration teams did not have regular meetings. A plan of formal meetings was being prepared but had not been implemented at the time of the inspection. We were told meetings became irregular during the COVID-19 pandemic due to the difficulties with staffing and access to communal meetings. The nursing team held a meeting each week but there were no minutes to reflect the issues discussed or enable staff who could not attend to share any learning or updates. We were provided with information after the inspection about a plan to keep 'brief notes' following each meeting that all staff could access. We were provided with minutes of the last reception team meeting which was held in November 2022. The meeting minutes showed staff had raised issues and discussed actions to reduce risk. • The practice took the views of patients into account. For example, following a complaint made by a patient, the process for supporting bereaved patients was reviewed and changed. 	

Feedback from Patient Participation Group (PPG).

<ul style="list-style-type: none"> • Feedback
<ul style="list-style-type: none"> • We spoke with a member of the PPG following the inspection. Meetings of the PPG together with the practice had been resumed following the pandemic, with a meeting planned for next month. • The PPG had good relationships and confidence in the registered provider. For example, when concerns or issues were raised to the practice they were addressed. We were told the uneven surface in the car park had been an issue and following discussion with the provider this had been resurfaced. Patients had previously had difficulties with accessing the practice. Following a discussion with the provider new reception staff had been appointed and the concerns received had been reduced. • The PPG told us of future plans to recruit new members and intended to go into schools to talk to children and families regarding the practice and the role of the PPG.

<p>Any additional evidence</p>
<ul style="list-style-type: none"> • The practice sought feedback from patients using the friends and family test. This is a short survey to find out how the patient had viewed the service received from the practice. We reviewed surveys which had been submitted during May 2023. These had not been audited to identify themes and trends. We asked if there were audits from previous surveys but were told this had not taken place. We reviewed 30 survey responses, all were positive with the exception of 2. These patients had made negative comments regarding their experience with access by telephone and availability of appointments.

Continuous improvement and innovation

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

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

Examples of continuous learning and improvement

- The practice employs an 'eldercare matron' who leads on the care of older patients and complex care within the practice. The eldercare matron support care homes and housebound patients by providing holistic care and liaison with community teams.
- However, there was limited evidence to demonstrate improvements were consistently made following complaints and significant events. This did not demonstrate a strong focus on learning and improvement, how this was shared effectively and used to make improvements.

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.