

Inspection Evidence Table

Hawthorn Medical Practice

(1-592683393)

Inspection Date: 19 April 2023.

Date of data download: 07/03/2023

Overall rating: Requires Improvement

We inspected this service on 23 August 2022 and rated it as Inadequate overall and specifically Inadequate for providing safe, responsive, and well-led services. We rated it as Requires Improvement for providing effective and caring services. The practice was placed into Special Measures.

On 14 December 2022, we conducted a focused inspection of the practice to follow up on matters included in Warning Notices issued for breaches of Regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was not a rated inspection.

On 19 April 2023, we undertook a full comprehensive inspection to enable us to rate the practice and determine if sufficient progress had been made to enable Special Measures to be removed.

We rated the practice as Requires Improvement overall. It was rated as Requires Improvement for providing safe, effective and responsive services and Good for providing caring and well-led services.

Safe

Rating: Requires Improvement

At our inspection on 23 August 2022, we rated the practice as Inadequate for providing safe services. This was because:

- Not all staff were trained to appropriate levels.
- Recruitment procedures were not effective.
- There was no assurance that Health and Safety and infection prevention and infection control measures were effective.
- There were gaps in systems to assess, monitor and manage risks to patient safety.
- The practice did not have systems for the appropriate and safe use of medicines, including medicines optimization.
- There was no assurance regarding the safety of dispensing services.

At this inspection on 19 April 2023, we found that many of the issues had been resolved however, there were still issues with health and safety, records of staff vaccination status and the process of dealing with patient safety alerts.

Safety systems and processes

The practice generally had systems, practices, and processes to keep people safe and safeguarded from abuse, but further work was required.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	No (1)
Explanation of any answers and additional evidence: (1) The practice provided us with details of the vaccination status of GPs and staff. However, this only detailed Hepatitis B and measles, mumps and rubella (MMR) status and did not include other immunisations as required by the guidance and best practice contained in 'The Green Book' (Immunisation of Healthcare and laboratory staff) issued by the UK Health Security Agency. There were no records for 10 members of staff.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Partial (1)
Date of last assessment:	19 October 2022
There was a fire procedure.	Yes (2)
Date of fire risk assessment:	30 Jan 2023

Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>(1) At our previous inspection in August 2022, we saw that blind cords had not been secured in line with guidance to avoid them becoming ligature points. We were told that this was in hand and consideration was being given to replacing the blinds with opaque window film. At this inspection we saw that no changes had been made. We raised this with leaders who again informed us that opaque window coverings were being considered.</p> <p>(2) There was evidence of regular checks on fire alarm systems and equipment to be used in the event of fire. There were records of fire drills which included the evacuation of the premises both at Burgh le Marsh and Skegness sites.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audits:	10 August and 21 September 2022
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection on 23 August 2022, we found numerous issues relating to inadequate cleaning and other infection prevention and control issues. At this inspection all had been satisfactorily addressed.</p> <p>A room at the Burgh le Marsh branch surgery was being converted into a treatment room and that it was almost complete. The room had not yet been used in the delivery of the Regulated Activities. However, we saw that a new hand wash sink was not compliant with latest infection prevention and control guidance. We brought this to the attention of the provider who assured us that it would be replaced prior to the room being commissioned as a treatment room.</p>	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes

There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours.	Yes

Information to deliver safe care and treatment.

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

	Y/N/Partial
Individual care records, including clinical data, were written, and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results, and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes

Appropriate and safe use of medicines

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

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

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) <small>(NHSBSA)</small>	1.35	1.04	0.82	Variation (negative)
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). (01/10/2021 to 30/09/2022) <small>(NHSBSA)</small>	10.3%	11.4%	8.5%	No statistical variation

Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2022 to 30/09/2022) (NHSBSA)	7.32	5.38	5.28	Significant variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	350.5‰	224.0‰	129.7‰	Variation (negative)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)	1.02	0.81	0.58	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	9.2‰	8.2‰	6.7‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes (1)
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 (2)
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes (3)

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.	Partial (4)
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>Whilst the prescribing data for antibacterial, pregabalin, gabapentin, hypnotics and multiple psychotropics was higher than the ICB and national averages it was comparable to other local practices and was reflective of the patient demographics.</p> <p>(1) At our inspection on 23 August 2022 there was no audit to demonstrate the prescribing competence of non-medical prescribers, and there was no review of their prescribing practice supported by clinical supervision or peer review. At this inspection we were provided with evidence of the audit of non-medical prescribers undertaken monthly.</p> <p>(2) We looked at the records of patients prescribed disease-modifying antirheumatic drugs (DMARD) The search results indicated that required monitoring had been performed within last 6 months for all patients prescribed DMARDs.</p> <p>For patients prescribed Angiotensin converting enzyme inhibitors (ACE inhibitors), angiotensin receptor blockers (ARBs) and thyroid monitoring, the records indicated blood tests were up to date for most patients. For those that were not of a random selection of patients showed that for the patients reviewed, where blood tests were overdue, letters had been sent to the patient advising of the need for a blood test. The practice had taken every reasonable step to inform patients of the necessity for blood tests.</p> <p>(3) At our inspection on 23 August 2022 the practice did not provide us with any evidence to show that they had taken steps to ensure the appropriate prescribing of these antimicrobials. At this inspection we saw evidence that the practice had completed audits into the prescribing of 6 different antimicrobials, including Trimethoprim and amoxicillin to gain assurance of appropriate prescribing.</p> <p>(4) At our inspection on 23 August 2022 the emergency medicines did not contain two medicines to be used in the case of a medical emergency, midazolam and diclofenac. There were no risk assessments in place to cover the omission of these two medicines. At this inspection we found that the emergency medicines did not contain naloxone, which is a medicine that rapidly reverses the effects of an opioid overdose. There was no risk assessment in place to cover the exclusion.</p>	

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.	Yes
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.	Yes
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
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	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> <p>At our inspection in August 2022, we found:</p> <ul style="list-style-type: none"> • There was no system for ensuring that dispensers had the competence, skills and experience to dispense medicines safely. • There was no effective process to ensure the appropriate storage of medicines in the dispensary. Room temperatures were not routinely monitored and there was no process in place to ensure that the temperature was regulated to ensure the efficacy of medicines. • There was no effective system for recording and acting upon dispensing errors and near misses. <p>At this inspection we found:</p> <ul style="list-style-type: none"> • Additional experienced dispensers had been recruited and the practice was actively seeking to fill the post of dispensary manager. • We saw evidence that competency checks and revised standard operating procedures were in place. • Air conditioning had been installed in the dispensary, which was set to automatically cool the air when the pre-determined temperature was reached. • There was an effective and simple to use system in place to record both dispensing errors and near misses and we saw that it had been used several times since its induction. 	

Track record on safety and lessons learned and improvements made.

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded since the last inspection:	13
Number of events that required action:	all

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

Event	Specific action taken
Inappropriate medicine left on repeat prescription. No patient harm as the error was recognised by the patient.	Learning was disseminated to all prescribers to remove medicines not required from the list on repeat prescriptions.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: Patient safety alerts were received by the Finance Manager. We received assurance that they were dealt with correctly and reviewed by one of the GP partners who distributed them for the appropriate action. The practice agreed that this may not be the most effective or safest way of receiving and dealing with alerts and agreed to take advice from a representative of the Local Medical Committee on improving the process. For example, in Nov 2019 the MHRA issued a Drug Safety Update detailing the rare but serious and potentially life-threatening risk of Fournier's gangrene with SGLT-2	

inhibitors. Searches of 4 patients revealed evidence of advising all 4 patients reviewed taking SGLT-2 inhibitors about this risk by letter on 24/01/23.	
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Effective

Rating: Requires Improvement

At our inspection on 23 August 2022, we rated the practice as Requires Improvement for providing effective services. This was because:

- The management of people with long term conditions was not always effective.
- The practice was not always unable to demonstrate staff had the skills, knowledge or experience to carry out their roles.

At this inspection on 19 April 2023, we have again rated the practice as Requires Improvement.

This was because:

- The practice had no system in place to ensure the management of people with the long-term condition asthma was effective.
- The uptake of screening of females for breast cancer was very low.
- The uptake of screening for cervical cancer was low.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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.	Yes
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.	Yes

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings
<p>The clinical searches identified 151 patients with asthma who had been prescribed two or more courses of rescue steroids. We reviewed the records of 5 of those patients and found they had not been reviewed in line with national guidance, which would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm. NICE guidance advises that patients should be reviewed within 48 hours of an acute exacerbation of asthma. This had not occurred in the records we examined.</p> <p>The clinical searches showed that there were 6 patients with hypothyroidism who have not had thyroid function test monitoring for 18 months. However, we saw that letters had been sent to the patients advising blood tests were required on multiple occasions.</p> <p>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.</p> <p>Staff who were responsible for reviews of patients with long-term conditions had received specific training.</p> <p>The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.</p> <p>Adults with newly diagnosed cardio-vascular disease were offered statins.</p> <p>The time allocated for nurse consultations did not always reflect the time required. For example, we saw that if a patient was being reviewed for two long-term conditions, then a double appointment was allocated, but if a patient was being reviewed for three respiratory long-term conditions, one appointment slot was allocated.</p>

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	123	131	93.9%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	129	143	90.2%	Met 90% minimum

The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	129	143	90.2%	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)	128	143	89.5%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	125	150	83.3%	Below 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
Staff were made aware of the slightly lower than the minimum target for children receiving the MMR immunisations. We saw evidence of staff making efforts to get parents to bring children in for immunisation with repeated calls and ad-hoc requests.

Cancer Indicators	Practice	SICBL average	England	England comparison
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	18.9%	67.0%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	63.3%	70.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	53.2%	57.9%	54.9%	No statistical variation
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). (30/09/2022 to 30/09/2022) (UKHSA)	68.0%	N/A	80.0%	Below 70% uptake

Any additional evidence or comments
The partners were surprised by the low screening rate for breast cancer. They asserted that this was a coding issue but were unable to explain how this was the case. They provided evidence from their

clinical system that indicated that the current figure was 48.6%. We acknowledged that the data was more than two years old and may not reflect the true picture but as the screening scheme was not administered by the practice up to date data was not accessible. The data period coincided with the Covid 19 pandemic and that may have had an effect on screening uptake.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes
Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years: The practice had completed clinical audit on the prescribing of SABA inhalers, atrial fibrillation, DMARDs and citalopram use in the over 65s. These had resulted in improved outcomes for patients.	

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes (1)
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes (2)
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes

There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>(1) At our previous inspection staff we spoke with told us they did not have any protected time for learning and had to do it (including the provider's essential training) in their own time. Following that inspection, the practice had introduced monthly protected learning time and staff we spoke with confirmed it provided the opportunity to complete their training.</p> <p>(2) At our previous inspection we were provided with a timetable showing when staff appraisals were due to take place, but the practice could not supply us with details of when the last appraisals had been carried out. At this inspection we saw that all due appraisals had been carried out.</p>	

Coordinating care and treatment.

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

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

Helping patients to live healthier lives.

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes

Caring

Rating: Good

At our previous inspection on 23 August 2022, we rated the practice as Requires improvement for providing caring services.

This was because:

- The provider could not demonstrate that they had taken any action to understand the deterioration in satisfaction levels or any actions to improve.

We rated the practice as Good at this inspection on 19 April 2023.

This was because:

- We had seen a significant reduction in the number of complaints received about the practice.
- The providers own survey of patients showed improved levels of satisfaction.

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
Healthwatch Lincolnshire	Since the inspection in August 2022 Healthwatch Lincolnshire had received 8 negative comments about the practice.

National GP Patient Survey results

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

Indicator	Practice	SICBL average	England	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)	68.1%	83.5%	84.7%	Variation (negative)

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)	68.5%	83.3%	83.5%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	85.8%	92.9%	93.1%	Tending towards variation (negative)
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)	58.9%	72.2%	72.4%	No statistical variation

Any additional evidence or comments

The practice had conducted its own patient survey in January and February 2023. The results were much improved upon the National GP Survey results, which reflected patient experiences prior to the August 2022 inspection.

77% of patients said the receptionists were helpful.

81% of patients said they were treated with care and concern.

83% of patients said the clinician listened and understood.

77% of patients said their needs were met.

84% of patients said their overall experience was good or very good.

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

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence: Information was displayed on the reception desk in multiple languages. Some GPs were multilingual and could communicate in Urdu, Hindi, Kannada, Punjabi and Arabic.	

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)	86.1%	89.5%	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.	Partial (1)
Information about support groups was available on the practice website.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>(1) Asylum seekers were housed in local hotels, and many had been registered as patients at the practice. Consequently, there had been increased use of interpretation services to meet the needs of this cohort of patients. Consultations with patients in this group were always undertaken with the assistance of interpreter services.</p> <p>(2) Polish was the most commonly non-English language used by patients. Leaflets in Polish were available.</p> <p>(3) Some GPs were multi-lingual and able to communicate with patients in Urdu, Hindi, Kannada, Punjabi and Arabic.</p>	

Carers	Narrative
Percentage and number of carers identified.	707 (4% of the patient list)
How the practice supported carers.	<p>The patient registration pack asked whether new patients are carers or have carers.</p> <p>The practice offered flexible appointments for patients who need carers and for carers working around the people they look after.</p> <p>The practice used and actively promoted a form to enable the person with care needs to give consent to sharing information with their carer.</p> <p>When patients had dementia or suspected dementia, GPs advised that it is important to get a diagnosis as this can also help support the carer. The</p>

	<p>patients and their carers were be signposted to dementia support Services.</p> <p>In addition to the needs of the patient, carers were also asked about any stress they might be under and whether they have had any time off. This enabled GP to assist in arranging respite care to give carers, especially if they are partners, a break.</p>
How the practice supported recently bereaved patients.	Letter of condolence sent to the next of kin.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Responsive

Rating: Requires Improvement

At our previous inspection on 23 August 2022, we rated the practice as Inadequate for providing Responsive services. This was because:

- People were not always able to access care and treatment in a timely way.
- The practice had not responded to deteriorating levels of patient satisfaction.
- It was unclear how learning from complaints had been used to improve the quality of care.

At this inspection on 19 April 2023, many of the issues had been addressed and we have rated the practice as Requires Improvement for providing Responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs/ Services did not 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.	No (1)

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
<p>Explanation of any answers and additional evidence:</p> <p>(1) At our previous inspection on 23 August 2022 the partners told us that a lack of space for consultation rooms as well as administration functions were a barrier to improving services, for example providing minor surgery, but also due to recruitment as there was nowhere to accommodate staff. Negotiations with NHS Property Services for the practice to extend into adjoining unused space in the same building and formerly used by community nursing, had been protracted and gone on for at least three years. Staff expressed their frustrations about the delays and the negative effect it was having on staff and their desire to enhance patient services. At the time of this inspection no progress had been made in this matter.</p>	

Practice Opening Times	
Day	Time
Opening times: Skegness	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Opening times: Burgh le Marsh branch surgery	
Monday	8.30am to 5pm
Tuesday	8.30am to 5pm
Wednesday	8.30am to 5pm
Thursday	8.30am to 12 midday
Friday	8.30am to 5pm
Extended hours appointments are available through a hub arrangement. These are available most weekday evening from 6pm until 8pm and weekends and bank holidays from 9am until 5 or 6pm.	

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> Patients had a named GP who supported them in whatever setting they lived.

<ul style="list-style-type: none"> • The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. • The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues. • The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability. • People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers. • The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. • The practice had responded to the need for asylum seekers temporarily housed in local hotels to have effective and timely healthcare.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes
Patients were able to make appointments in a way which met their needs.	Yes
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised.	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes
Explanation of any answers and additional evidence: The practice has converted a room at the Burgh Le Marsh branch surgery to become a clinical room to provide additional nurse or GP appointments over and above those already available at the surgery.	

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)	21.0%	N/A	52.7%	Significant variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	35.6%	59.3%	56.2%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	38.5%	56.6%	55.2%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	68.0%	76.3%	71.9%	No statistical variation

Any additional evidence or comments

Since the inspection in August 2022 the practice had taken steps to improve telephone access and were now able to view the call data held in the telephony system to obtain such data as call volumes, abandoned calls and call waiting times. The analysis of this data enabled managers to use staff more effectively in answering and dealing with calls at times of peak demand. Performance was reviewed daily, and adjustments made as required. Lack of reception staff and un-planned staff absence had a major impact on call handling performance as could be seen when comparing performance with staffing levels. The practice had recruited additional staff, one had started work two days prior to the inspection and two more were due to start soon after. The practice was exploring possible means of incentivising staff to help reduce un-planned absence.

Managers accepted that at times the wait for calls to be answered was too long, but without data to compare with other practices it was difficult to say what an acceptable wait was. It was apparent that steps taken by the practice had substantially reduced the volume of abandoned calls.

The provider had taken steps to increase the number of appointments, including face to face, on-line and telephone available to patients.

The conversion of a room at the Burgh le Marsh branch surgery to a clinical room provided the physical space to provide more face-to-face consultations. Space had been an issue for some years, with the patient list having long outgrown the building at Hawthorn Road.

None of the complaints recorded by the practice since the last inspection in August 2022 concerned a lack of appointments.

Source	Feedback
NHS.uk website (formerly NHS Choices)	One comment had been posted on the NHS website since our August 2022 inspection. It was of negative sentiment regarding non- NHS GP services and not applicable to the practice.
Healthwatch Lincolnshire	Healthwatch had received one comment regarding long telephone waiting times since the inspection in August 2022.

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	13
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient complained that she had been prescribed Oramorph which contained alcohol. Patient was a recovering alcohol abuser and felt this broke their sobriety.	All prescribers were reminded that Oramorph contains alcohol and to be mindful when prescribing.

Well-led

Rating: Good

At our inspection on 23 August 2022, we rated the service as Inadequate for providing well-led services. This was because:

- Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.
- There was no credible strategy to provide high quality sustainable care.
- The overall governance arrangements were ineffective.
- The practice did not have clear and effective processes for managing risks, issues and performance.
- The practice did not always act on appropriate and accurate information.
- In the absence of a patient participation group or other patient forum the practice did not always involve the public, staff and external partners to sustain high quality and sustainable care.

At this inspection on 19 April 2023, we found the issues had been successfully addressed and we have rated it as Good for providing well-led services.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	No (1)
Explanation of any answers and additional evidence:	
(1) The practice consisted of 8 GP partners. The partnership was stable, and succession was not considered to be an issue.	

Vision and strategy

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

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

A very experienced managerial assistant, formerly a practice manager in another practice, had recently been recruited and was proving valuable advice and assistance in the running of the practice.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: Staff feedback (see below) indicated dissatisfaction with the wages on offer. Managers were aware of this but financial constraints, especially given the squeeze on practice finances as a result of the new 2023/24 GP contract made any meaningful increase extremely difficult.	

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

Source	Feedback
CQC feedback forms	<p>Prior to the inspection we gave all staff the opportunity to anonymously, if they so wished, provide us with written feedback about their experience of working at Hawthorn Medical Practice. We received feedback from 12 of the 33 members of staff employed at the practice.</p> <p>Generally, staff expressed positive views about working at the practice and their relationships with other members of staff. However, low remuneration, even when given additional responsibilities such as patient triage, was cited as a cause for some dissatisfaction and difficulties in recruiting and retaining staff.</p> <p>Some staff said they felt undervalued. Low staff levels were stated as cause for concern, particularly in reception.</p>

	<p>Some staff thought that they were not always supported by the partners and that some partners did not give enough support to senior managers and the Senior Partner.</p> <p>Staff stated that the job had become more stressful as the demands and (sometimes unachievable) expectations of patients had increased.</p> <p>Clinical staff were not routinely invited to attend meetings to be updated on safeguarding, serious events, complaints or safety alerts.</p>
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Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	N/A
Explanation of any answers and additional evidence:	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence:	

At our previous inspection on 23 August 2022 the practice did not have clear and effective processes for managing risks, issues and performance. At this inspection we found that these issues had been addressed and there were clear and effective systems and processes to assess and manage risk. This included the risks from healthcare associated infections, fire and business continuity.

Senior managers were focused on performance, both clinical and non-clinical.

The Business Continuity Plan was thorough, comprehensive, and contained up to date details of staff members and contact details.

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes

Governance and oversight of remote services

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes (1)
The practice had an active Patient Participation Group.	Partial (2)
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: (1) Prior to the inspection in August 2022 there had been high numbers of complaints regarding the difficulty in gaining access to the practice by telephone. The provider had responded by conducting analysis of the incoming called data and adjusted staffing to help meet peak demand for telephone answering. Improvements had been made although good response times were dependent upon having enough staff to deal with calls, which had been a problem. New reception staff were due to start shortly, and one had started work at the practice two days before our inspection. (2) At our previous inspection in August 2022 there had been no patient participation group at the practice for several years. Since that inspection the practice had worked hard to establish a new group and we saw that they had been successful in generating interest. The first full face to face meeting was due shortly after the inspection took place.	

Continuous improvement and innovation

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

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

Examples of continuous learning and improvement

Following our inspection in August 2022 the practice had introduced protected learning time on one afternoon a month that gave the opportunity for all staff to focus on their learning and development.

The partners supported staff to develop their careers in healthcare which included supporting them to move to other services or training to allow them to progress.

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.