

Inspection Evidence Table

Caskgate Street Surgery

(1-576042105)

Inspection Date: 24 May 2023

Date of data download: 10/05/2023

Overall rating: Inadequate

We rated the practice as Inadequate overall because :-

- The practice did not provide care in a way that kept patients safe and protected them from avoidable harm.
- There were gaps in systems to assess, monitor and manage risks to patient safety.
- Staff did not have the information they needed to deliver safe care and treatment.
- Patients' needs were not assessed, and care and treatment was not delivered in line with current legislation.
- Leaders could not demonstrate they had the capacity and skills to deliver high quality sustainable care.
- The overall governance arrangements were inadequate.

Safe

Rating: Inadequate

We rated the practice as Inadequate for the Safe key question because:

- The practice did not have systems and processes in place to keep people safe.
- There was poor oversight and maintenance of the premises including fire, legionella, health, and safety.
- The practice was not able to demonstrate that all staff had completed safeguarding training or were trained to the required level.
- We were not assured that staff had the information they needed to deliver safe care and treatment due to a backlog of correspondence.
- Medicines management required greater oversight to provide assurances that medicines were monitored effectively, and that patients received timely reviews of their prescribed medicines.
- There was poor management of care information and task management issues.
- The practice could not demonstrate the prescribing competence of non-medical prescribers and those in Additional Roles Reimbursement Scheme (ARR) roles.
- There was not an effective system in place for patient safety alerts.

Safety systems and processes

The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	No ¹
Partners and staff were trained to appropriate levels for their role.	No ²
There was active and appropriate engagement in local safeguarding processes.	No
The Out of Hours service was informed of relevant safeguarding information.	No
There were systems to identify vulnerable patients on record.	No ³
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes ⁴
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.	No ⁵
<p>Explanation of any answers and additional evidence:</p> <p>1. On the day of the inspection we found the system in place to safeguard service users from abuse and improper treatment was not effective. There was a lead GP for safeguarding. Staff we spoke with and those who completed staff questionnaires were aware who had responsibility for safeguarding. The practice was unable to tell us if any safeguarding referrals had been made. We asked for a list of patients on the safeguarding register and how many children were looked after children or under a child protection plan, but the practice had two different registers and the numbers of children did not correspond. The practice was unable to tell us if all the patients who were on the safeguarding register had icons or alerts on the patient record system. Records reviewed demonstrated that icons and alerts had not been applied, for example, identification of siblings within a family.</p> <p>2. On the day of the inspection we could not be assured that all staff were competent to recognise adults and children at risk, understand their individual responsibilities and take effective action as appropriate. We were not able to see if all the GPs were up to date with training on safeguarding children and vulnerable adults relevant to their role as certificates were not available. We found concerns as we could not be assured that safeguarding referrals had been made in a timely manner and the safeguarding register on the patient record system in place to protect children and young people was not effective.</p> <p>We found that the practice did not have a vulnerable adults safeguarding register on the patient record system, to ensure that staff were kept aware and able to take steps to provide safe care and treatment.</p> <p>3. There was no system in place to identify vulnerable adults.</p> <p>4. We found that staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be</p>	

vulnerable). Notices in the waiting room and clinical rooms advised patients that chaperones were available if required.

5. There were no safeguarding multi-disciplinary meetings held by the practice or minutes of any meetings that had taken place in regard to safeguarding discussions.

Since the inspection, the Lincolnshire Integrated Care Board Safeguarding team visited the practice on 1 June 2023 to review the system in place for Safeguarding and they will be supporting the practice to make improvements over the coming weeks.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes ¹
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial ²
Explanation of any answers and additional evidence: 1. Risk assessments were in place for those staff who did not require a Disclosure and Barring (DBS) check. Clinical staff had a DBS check every three years. 2. Staff vaccination records were in place for clinical staff but no records had been collated for non-clinical 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: Reception - 11 January 2023 Waiting Area – 11 January 2023	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 22 August 2022	Yes ²
Actions from fire risk assessment were identified and completed.	No ³
Explanation of any answers and additional evidence: Caskgate Street Surgery is an 18 th century Grade 2 listed building. It had been at the top of the estates strategy for the Lincolnshire Integrated Care Board (ICB) for the past 7 years for a new building. When we contacted the ICB and asked for information on the progress we were told that the ICB were already in discussion with a local council to explore options for a site relocation. The ICB was also exploring options regarding long term accommodation. The ICB continues to look at options for temporary accommodation to provide additional estate capacity in the interim.	
1. We were provided with a legionella risk assessment date 18 March 2021. Remedial actions were advised to carry out water temperature monitoring in all rooms. We found that water temperature monitoring for all the clinical rooms had not been undertaken. 2. A fire risk assessment had been completed in August 2022 by an external company. We found that it had not identified the lack of emergency lighting to floors 2 and 3. The replacement of two bulkheads had been identified as urgent actions in February 2022 and February 2023 and on the day of the inspection these	

actions had not been completed. Whilst 6 monthly checks of emergency lighting were carried out by an external company no regular checks were carried out by the practice. Since the inspection, the practice have told us that they had replaced the two bulkheads and additional emergency lighting will be installed to floors 2 and 3 on 7 June 2023.

3. Fire wardens were in place.
4. A fire drill had taken place on 22 May 2023. A report had been completed and a further drill was planned in one month's time.
5. At the time of the inspection there was no documentary evidence to demonstrate that visual checks of the building had taken place on a regular basis.
6. We found Lloyd George patient notes in different locations within the practice, across both the ground and first floors. The patient notes were on open shelving and had no security from unauthorised access or reasonable protection from fire or flood. No risk assessment was in place. This had been highlighted to the Lincolnshire Integrated Care Board for a number of years and the practice were told that they were top of the list for the removal and digitisation of notes.
7. There was a record of portable appliance testing (PAT) or visual inspection by a competent person: Date of last inspection/test: 17 October 2022
8. There was a record of equipment calibration. Date of calibration: 17th October 2022
9. We were provided with an electrical installation condition report (EICR) dated November 2016 which recommended that a reinspection take place every five years. The practice was unable to provide any evidence of a re-inspection being completed, or any actions taken following the inspection. Since the inspection, the practice told us a further EICR inspection was booked for 3 June 2023.
10. On the day of the inspection, we were not provided with a gas inspection certificate to assure us that the two gas boilers were safe.

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 ¹
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit: 5 April 2023	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes ²
The arrangements for managing waste and clinical specimens kept people safe.	Yes ³

Explanation of any answers and additional evidence:

1. The lead nurse had recently been given the role of infection control lead. and Although they had received infection control lead training, they did not have allocated time in which to carry out this role.
2. Despite the age and complexity of the building at Caskgate Street Surgery we saw that clinical areas were visibly clean and dust free. Action plans were in place following the last infection prevention and control audit and we saw evidence that some issues identified had been resolved or mitigated. Building and remedial work was required but the practice had been waiting to move to a new building for the past 7 years. The practice had been at the top of estates strategy for Lincolnshire Integrated Care Board (ICB) for the past 7 years for a new building. When we contacted the ICB and asked for information on the progress we were told that the ICB were already in discussion with a local council to explore options for a site relocation.

Cleaning schedules were in place which identified daily, weekly and monthly required tasks. External quality visits by the Lincolnshire ICB team for infection prevention and control (IPC) had taken place in September and November 2022 and again on 16 May 2023. Actions were identified and most were completed. The ICB IPC team told us that the practice were able to demonstrate continued and sustained improvements in infection control practice. Systems and processes for IPC had been embedded, and improvements were noted in the clinical rooms in line with the feedback they gave during previous visits. The practice IPC Lead and Practice Manager had demonstrated excellent engagement with the ICB Health Protection Team in identifying areas for improvement and implementing changes. We were therefore assured that measures to monitor infection prevention and control were in place.

Cleaning materials were appropriately stored in a locked cupboard with control of substances hazardous to health (COSHH) risk assessments in place and accessible.

3. Arrangements were in place for the management of clinical waste. Clinical waste bins were locked and chained to an outside wall.

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 ¹
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
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. We were informed that there had been increased reliance on locum GPs at the practice recently, but it was acknowledged that more permanent GP and other clinical input was needed. The practice told us it was proactively trying to recruit more GPs, and that the situation had been impacted upon by retirement and long-term absence. 	

Information to deliver safe care and treatment.

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

	Y/N/Partial
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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 ¹
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.	Partial ²
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial ²
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. On the day of the inspection, we looked at the system the practice had in place for the summarisation of patient notes and found that it was ineffective and there was no practice policy in place. We were told that there was a backlog of patient records that required summarisation. We were told that there were currently approximately 1,200 patient records to be summarised which dated back two years. There was no oversight to determine which records should be prioritised for summarisation. There was no documented action plan in place to identify how the backlog would be managed. Therefore, we could not be assured that care records were managed in a way to protect patients. 2. On the day of the inspection we found that there was a backlog of incoming clinical and non-clinical correspondence which required reconciliation. We found 2138 tasks and letters still in an inbox waiting to be coded, scanned and actioned which dated back to 17 April 2023 onwards. Therefore, we could not be assured that care records were managed in a way to protect patients. 	

Appropriate and safe use of medicines

The practice did not have all the systems in place 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) <small>(NHSBSA)</small>	1.11	1.09	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) <small>(NHSBSA)</small>	15.4%	11.2%	8.1%	Significant variation (negative)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and	5.34	5.35	5.24	No statistical variation

Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2022 to 31/12/2022) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	244.2‰	224.3‰	130.3‰	Tending towards variation (negative)
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)	1.01	0.79	0.56	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2022 to 31/12/2022) (NHSBSA)	12.7‰	8.4‰	6.8‰	Variation (negative)

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).	No ¹
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 ²
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	No ³
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.	No ⁴
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).	No
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	N/A
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	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 ⁶
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.	Partial ⁷
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ol style="list-style-type: none"> 1. We found that Patient Group Directives (PGD's) were in place, but these had not been signed by the authorising manager. Since the inspection, the practice told us these have all been signed by the lead GP. 2. There was no oversight of the prescribing practices of non-medical prescribers or Additional Roles Reimbursement Scheme (ARRS) roles to ensure correct prescribing practices were in place. From records we reviewed we did not find any evidence of risk to patient safety. 3. There was no effective system in place for carrying out medication reviews. During the inspection we saw evidence that the code 'medication review' was being added to patients records in line with the surgery policy. However, it was not effective as it was not documented what had been reviewed and just had logged in the patient record for a further date to be added in the future for a review to take place. We also saw evidence where this code had been added and the record did not appear to consider or address all the potential concerns with the treatments prescribed. The practice prescribing policy stated that a medication review should be carried out at least annually or, in cases of complex repeat prescriptions, six months. There was no audit process in place to provide reassurance that a full and appropriate review had been undertaken and reviewed in a timely manner and did not always receive regular monitoring in accordance with national guidance. 4. We were told that it takes approximately four to five weeks for changes in medication recommended by secondary care to be actioned. 5. We found that the anaphylaxis kit in a treatment room did not contain any antihistamines such as Chlorphenamine or an alternative. No risk assessment was in place. Since the inspection, the practice told us that this is now in place both oral and intramuscular. 6. We found gaps in the monitoring of the cold chain. We reviewed the monthly checklists and found that when one staff member was absent from work the vaccine refrigerators did not get checked as per the practice policy. We also found that data logger downloads were not regularly downloaded and reviewed. Since the inspection, the lead nurse has advised us that they have downloaded the data from both fridges and have trained new members of staff to download and review on a daily basis as well as organised cover for staff days off. 	

Any additional evidence

The CQC's GP SpA reviewed the patient records via remotes searches and checked the system in place for the management of medicines, which included regular monitoring in accordance with national guidance. We found:-

- Patients were not always having the blood tests required to ensure they were safe to continue taking their prescribed medicines.

- We found that the 30 patients were prescribed Methotrexate and in 5 patient records we reviewed we found they did not have instructions on what day of the week to take the medicine as per a MHRA safety alert in 2020. This was to prevent an accidental fatal overdose. 1 patient out of 5 patient records reviewed had also not received any up to date blood monitoring.
- There was a lack of evidence to demonstrate that patients had an up-to-date care plan in place which meant that patients did not always have an accurate documented record of their individual requirements available to staff.

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.	No ¹
Number of events recorded in last 12 months:	58
Number of events that required action:	58
Explanation of any answers and additional evidence: 1. From staff we spoke with, completed staff questionnaires and minutes of practice meetings we reviewed we could not see where significant events and complaints were discussed and action and learning was disseminated.	

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

Event	Specific action taken
failure to action on medication changes from an electronic discharge document (EDD)	Volume of documents for scanning and coding raised with governance GP and Practice Manager. Additional hours arranged for staff to reduce backlog of documents.
failure to action task from GP	Volume of tasks raised with governance GP and Practice Manager. Additional hours arranged for staff to reduce backlog. Additional reception staff to be recruited.

Safety alerts	Y/N/Partial
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There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	No ¹
<p>Explanation of any answers and additional evidence:</p> <p>1. We found that the practice did not have an effective system for ensuring that Medicines & Healthcare products Regulatory Agency (MHRA) and patient safety alerts were received and actioned appropriately. The practice had a safety alert spreadsheet in place but we found that it was not inclusive of all the alerts distributed by the various agencies. There was no evidence that the practice had received a recent safety alert for the Emerade alert dated 9 May 2023. (Emerade is used for emergency treatment of severe allergic reactions (anaphylaxis) caused by allergens in foods, medicines, insect stings or bites and other allergens as well as triggered by exercise or unknown causes). The practice could not demonstrate they had received this alert or any action taken. We also found an alert received in January 2023 for topical testosterone that was documented as not relevant to the practice. However, they had not checked to see if they had any patients on this medicine. We did not find any evidence from meeting minutes we reviewed of how they had been shared and actioned.</p> <p>We found the practice were not reviewing old MHRA and patient safety alert searches. No system was in place to carry out searches of historic safety alerts to see if any new patients were affected or placed on medication after an alert has been issued).</p> <p>We found 17 patients prescribed both Clopidogrel and Omeprazole or esomeprazole. We reviewed 5 patient records and found that these patients needed a review as these medicines were less effective when taken together.</p> <p>We found 12 patients on Citalopram 40mg or Escitalopram 20mg which in patients over 65 can cause increase in QT interval (QT interval is the time from the start of the Q wave to the end of the T wave, time taken for ventricular depolarisation and repolarisation of the heart) and therefore risk of arrhythmia or sudden death. We reviewed 1 patient record and found they had had a review but the risks had not been considered.</p>	

Effective

Rating: Requires Improvement

We have rated the practice as Requires Improvement for the Effective key question because:-

- Patients with long-term conditions or potential long-term conditions had not received up to date monitoring and review.
- The practice could not evidence that staff had completed training required for their role.
- Staff did not always work together and with other organisations to deliver effective care and treatment.
- Patients did not have access to appropriate health assessments and checks.

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

Effective needs assessment, care and treatment

Patients' needs were not assessed, and care and treatment was not 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.	No ¹
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	No ²
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.	No ³
There were appropriate referral pathways to make sure that patients' needs were addressed.	No ⁴
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
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. Our remote clinical searches revealed that clinicians were not always following currently evidenced based practice. For example, we conducted a search of patients with asthma who have had 2 or more courses of oral steroids to manage acute asthma in the last 12 months. There were 74 patients identified, we examined 5 patient records. We found 4 of the 5 patients did not have a steroid card when one was deemed appropriate. During discussions with clinicians at the practice there was a lack of knowledge regarding awareness of this. 2. There were insufficient processes that patients immediate and ongoing needs were fully assessed. We were told and we saw that there was a backlog of tasks and correspondence from secondary care for patients to reduce medication for mental health needs and to start treatment to improve physical wellbeing. We found these had not been actioned and we were told by staff that these changes could take from 4-5 weeks to be actioned. 3. There was no effective system in place for carrying out medication reviews. During the inspection we saw evidence that the code 'medication review' was being added to patients records in line with the surgery policy. There was no evidence that a review of medicines had taken place, but it had been logged in the patient record for a further date to be added in the future for a review to take place. The practice prescribing policy stated that a medication review should be carried out at least annually or, in cases of complex repeat prescriptions, six months. 4. One the day of the inspection we found that the practice did not have a system relating to the monitoring of delays in referrals. 	

Effective care for the practice population

Findings

- The practice had 105 patients registered with a learning disability. The practice had completed 79 annual health checks.
- There were 4854 patients eligible for an NHS Health check of which 2547 were patients who had pre-existing conditions and were on a register to be monitored annually. The practice had sent out a further 259 invitations for a health check of which 257 had not responded and only 2 had been completed.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- We conducted remote clinical search of patients with a potential missed diagnosis of chronic kidney disease and identified a potential 61 patients. From these we reviewed 5 records of which 4 were not always 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.

Management of people with long term conditions

Findings

- Patients with long term conditions were not always reviewed to ensure their treatment was optimised in line with national guidance. There were 3396 patients registered with a long term condition.
- As part of our inspection we carried out a remote search of patients' clinical records. We found examples of unsafe care where patient treatment and care was not regularly reviewed or updated. For example: we looked at patients who were on more than 10 medicines. From the searches carried out we found that 235 out of 989 patients records did not demonstrate that a medication review had taken place in the last 18 months.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- We conducted a remote search of patients diagnosed with Chronic Kidney Disease (CKD) stage 4-5 who had potentially not received monitoring in line with national guidelines. The search revealed a potential 70 of 652. We reviewed 2 records and found 1 required monitoring and the other patient was monitored by secondary care.
- We conducted a remote search of patients who took a Potassium sparing diuretic medicine for the management of hypertension. Out of 23 patients who were prescribed this particular type of medicine for their long term condition we reviewed 3 records and found that 2 patients had not received the required blood test monitoring.
- We conducted a remote search of patients who took a medicine to treat or prevent heart rhythm disorders, such as atrial fibrillation. Out of 3 patients prescribed this particular type of medicine we found 2 had not received the required monitoring.
- Due to a backlog of correspondence and tasks on the clinical system the practice did not always share clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

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)	119	126	94.4%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received	106	123	86.2%	Below 90% minimum

Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)				
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)	104	123	84.6%	Below 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)	104	123	84.6%	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)	128	150	85.3%	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 aware of the lower than minimum target for children's immunisations. We saw evidence of staff making efforts to get parents to bring children in for immunisation with repeated calls and ad-hoc requests. The practice recognised that they needed to do further work to try and improve the rate of attendance.

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)	68.1%	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)	67.4%	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). (30/09/2022 to 30/09/2022) (UKHSA)	67.7%	N/A	80.0%	Below 70% uptake
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	56.5%	57.9%	54.9%	No statistical variation

Any additional evidence or comments

The partners were aware of the low screening rate for cervical screening which the practice felt could be due to the levels of deprivation in the area. They continued to send out recall letters to encourage patients to book an appointment and also did ad hoc discussions if a patient called to book for an appointment to see a clinician.

We reviewed data sent to us by the Lincolnshire ICB for Caskgate Street Surgery which showed cervical screening rates for November 2022 were 71% for ages 50-64 years and 63% for 25-49 years of age. Breast Screening July 2022. 67% for 50-70 years of age (England average was 61.5%) and 60% (England average was 52.5%) for 47-73 years of age. Bowel Cancer Screening – July 2022. 67% for 60-74 years of age (England average was 70.8%).

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes ¹
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.	No ²
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ol style="list-style-type: none"> 1. The practice had completed clinical audit on the prescribing of Direct oral anticoagulants (DOACs) and antiplatelet without gastric protection, splenectomy and pneumococcal vaccinations, betablockers and verapamil and patients on lithium. These had resulted in improved outcomes for patients. Re-audits were also planned to confirm that the improvements had been effective. 2. We saw data from the Lincs ICB for Caskgate Street Surgery which showed that A&E attendances for October and November 2022 was 565.6 which was greater than the Lincolnshire average of 391.8. All emergency admissions for September and October 2022 was 97.1% which was above the Lincolnshire average of 84.2%. 	

Effective staffing

The practice was unable to demonstrate that all 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.	No ¹
The practice had a programme of learning and development.	Yes

Staff had protected time for learning and development.	Partial ²
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.	Partial ³
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	No ⁴
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> <ol style="list-style-type: none"> 1. On the day of the inspection we found that the practice could not provide the evidence to demonstrate that the GPs at the practice had received any training. We also found that some staff had not completed training for sepsis, fire safety and dementia awareness. 2. From completed staff questionnaires and staff we spoke with we were told that due to the staffing and workloads protected time for learning and development was not always possible. 3. Most appraisals had been completed but formalised clinical supervision did not take place. 4. There was no performance monitoring of prescribing practices of non-medical prescribers or Additional Roles Reimbursement Scheme (ARRS) roles to ensure correct prescribing practices were in place. 	

Coordinating care and treatment

Staff did not work 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.	No ¹
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. On the day of the inspection, we found that there was no oversight or assurances that the practice responded to secondary care services or other organisations in a timely manner. From pre-inspection information we reviewed along with discussions that took place on the day of the inspection we identified 2138 documents outstanding that required review and actions to be taken which dated back to 17 April 2023. 	

Helping patients to live healthier lives.

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

	Y/N/Partial
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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.	Partial ¹
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 ²
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. We spoke with two residential care homes as part of the inspection process. One told us that they were supported by the EHCH care team (Enhanced health in care homes) team which is a PCN led initiative. They were contacted weekly and would review a new resident, support referrals and check the RESPECT (Recommended Summary Plan for Emergency Care and Treatment) forms. Whilst Caskgate Street Surgery were good with pre-emptive medicines and the relevant documentation the care home had difficulty getting a review of the medicines in a timely manner. 2. Patients did not always have access to appropriate health assessments and checks. For example, there were 4854 patients eligible for an NHS Health check of which 2547 were patients who had pre-existing conditions and were on a register to be monitored annually. The practice had sent out a further 259 invitations for a health check but only 2 had been completed. 	

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. 1	Yes ¹
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> 1. Our clinical review of notes where a DNACPR decision had been recorded found where possible that patients views had been sought and respected. We saw information have been shared with relevant agencies. Within Lincolnshire DNACPR forms have been replaced by Respect which also included care planning information 	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

	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
Explanation of any answers and additional evidence:	

Patient feedback	
Source	Feedback
Healthwatch Lincolnshire	During the past 2 years Healthwatch Lincolnshire had not received any complaints regarding Caskgate Street Surgery
Staff Interviews	In our interviews and from staff questionnaires, we found that staff were committed to providing the best care and services for patients. They were caring and patient-centred but needed more clarity and support from their employer to effectively address the issues that had arisen over the recent months.

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)	86.8%	83.5%	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)	86.7%	83.3%	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)	93.2%	92.9%	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)	70.9%	72.2%	72.4%	No statistical variation

	Y/N
The practice carries out its own patient survey/patient feedback exercises.	No

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: We saw notice boards in the waiting rooms to include further information of community and advocacy services including carers information, cancer and pregnancy support.	

Source	Feedback
Staff questionnaire responses	All spoke highly of practice manager and lead GP. Very supportive and had open door policy. Staff spoke highly also of colleagues who gave support and shared knowledge. Proud of work ethic and team spirit

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	88.4%	89.5%	89.9%	No statistical variation

wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)				
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	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
Explanation of any answers and additional evidence:	

Carers	Narrative
Percentage and number of carers identified.	178 carers were identified which represents approximately 1.5% of practice patient list.
How the practice supported carers (including young carers).	The practice had a carers champion. The practice were aware the number of identified carers needed reviewing and planned to complete this within the next 6 months. The carers champion acts as a key point of contact for carers.
How the practice supported recently bereaved patients.	At the time of the inspection there was no defined process for contacting bereaved patients. We were told that different GPs will reach out and put a courtesy call in if they had seen a patient recently.

Privacy and dignity

The practice were not always able to 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.	Partial ¹
Explanation of any answers and additional evidence:	
1. The practice were aware that the reception area was not confidential if patients wished to speak about a sensitive issue. They were able to access a separate rooms at time for these discussions to take place.	

Responsive

Rating: Good

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 ¹
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 ²
The practice made reasonable adjustments when patients found it hard to access services.	Yes ³
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: <ol style="list-style-type: none">1. Prior to the inspection the practice provided CQC with a summary of the quality of care it provided for the local population.2. The practice provided services from an 18th century Grade 2 listed building. It has been at the top of estates strategy for Lincs Integrated Care Board (ICB) for past 7 years for a new building. When we contacted the ICB and asked for information on the progress we were told that the ICB were already in discussion with a local council to explore options for a site relocation. The ICB is also exploring options regarding long term accommodation. The ICB continue to look at options for temporary accommodation to provide additional estate capacity in the interim.3. The practice told us and we saw that reasonable adjustments were made and rooms were made available on the ground floor should the need arise.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
GP Appointments available:	

Monday	8.30am –11.00am and 3.30pm to 5.30pm . Emergencies up to 6.30pm
Tuesday	8.30am –11.00am and 3.30pm to 5.30pm . Emergencies up to 6.30pm
Wednesday	8.30am –11.00am and 3.30pm to 5.30pm . Emergencies up to 6.30pm
Thursday	8.30am –11.00am and 3.30pm to 5.30pm . Emergencies up to 6.30pm
Friday	8.30am –11.00am and 3.30pm to 5.30pm . Emergencies up to 6.30pm

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

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- There were 2675 children and young people registered at the practice. All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice is open between 8am to 6.30pm Monday to Friday. The practice offered a range of appointment types including book on the day, telephone consultations and advance appointments. Extended access was provided locally by Cleveland Surgery where late evening and weekend appointments were available. Appointments were available between 6.30pm and 8pm Monday to Friday, 10am to 12 noon Saturdays and 10am to 11.30am on Sundays.
- 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.

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 ¹
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:	
1. We saw on the day of the inspection that the practice provided patients with timely access to appointments and had slots free throughout the day to meet the demand.	

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)	71.8%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	63.7%	59.3%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	60.3%	56.6%	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)	79.2%	76.3%	71.9%	No statistical variation

Source	Feedback
NHS.uk website (formerly NHS Choices)	We reviewed NHS choices before the inspection and found the practice had received three comments in the last 8 weeks. One was positive with them being seen and treated on the same day. Two negative responses in regard to Issue with sick note and a delay in getting prescription for antibiotics for a child
Google Reviews	10 responses in the last nine months. Positive comments regarding prescription timely processes, doctors and receptionists helpful. One of the best surgeries in Lincolnshire Negative comments in regard to phone access, lack of appointments, staff attitude prescription delay, phone call appointment not at allotted time.

Patient feedback received directly by CQC	Since December 2021 CQC had received 18 enquiries in relation to Caskgate Street Surgery. Of those 9 were positive, 7 were complaints. 6 complaints related to staff attitude and access to appointments. access, telephone call back concerns, medication reviews, registration issue of a vulnerable person and 1 complaint regarding how the practice was run, culture and lack of training.
Staff questionnaire responses	All spoke highly of practice manager and lead GP. Very supportive and had open door policy. Staff spoke highly also of colleagues who gave support and shared knowledge. Proud of work ethic and team spirit
Care Homes	CQC spoke with two care homes with one pleased with the responsiveness of this GP practice via email. Another care home told us they had difficulty getting through by phone and prescription turnaround times were too long.

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.	20
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	5
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0
<p>We found an effective system in place for receiving and acting on complaints. Complaints were received, investigated and necessary and proportionate action was taken. Complaints information on website and patient waiting areas, complaints leaflets and forms available from reception.</p> <p>However, from staff we spoke with, completed staff questionnaires and minutes of practice meetings we reviewed we could not see where significant events and complaints were discussed and action and learning was disseminated.</p>	

	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
Request for 2 month's medication not actioned causing distress to patient. Manner and attitude of staff member	A member of staff had not noticed request and apology offered that this was missed. Another member of staff attempted to explain the process and apologised that they found her manner unprofessional

	as this was not her intention. Team to complete Customer Care e-learning modules and Receptionist Masterclass.
Due to error a patient received products for another patient. Complaint about breach of information to third party.	Staff member did not check the correct patient record was open at time and therefore products issued to wrong patient – administrative error and apology offered. Staff member to complete Information governance and data security e-learning module. Apology offered for sharing info with outside agency however, reassurance that information remains confidential and not shared with anyone else.

We rated the practice as inadequate for the well led key question because:

- Leaders could not demonstrate they had the skills and/or capacity to deliver high quality sustainable care.
- Governance processes were ineffective.
- Processes for managing risks were poor.
- There was not always a supportive and open culture.
- The practice did not always act on appropriate and accurate information.
- The practice did not have clear and effective processes for managing risks, issues and performance.

Leadership capacity and capability

Leaders could not 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.	No ¹
They had identified the actions necessary to address these challenges.	No ²
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Partial ³
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. Due to changes at the practice in relation to GP partners and practice management over the last 12 months there had been periods of ineffective leadership. The practice leaders explained they had struggled to address all the challenges such as staffing shortages, training of staff and clinical governance. During the inspection, the practice leaders were not aware of the extent of the concerns found on the day of inspection. Since the inspection, the Lincolnshire Integrated Care Board Quality and Performance team had visited the practice on 31 May 2023 and were told that there are plans to employ two further GPs in the coming months with a view to them joining the practice partnership in the future. 2. We found a lack of oversight to ensure the practice performance and governance systems were in place and monitored effectively to ensure staff were fully supported and patients received safe care and treatment. We found shortfalls in some areas for example, the practice did not have clear systems practices and processes to keep people safe and safeguarded from abuse, lack of effective systems for the appropriate and safe use of medicines, which included medicines optimisation. These risks had not been identified by the practice, therefore no actions had been taken to mitigate the risks to keep patients safe from harm. 3. Since the last inspection in 2016 the partnership at Caskgate Street Surgery had gone from 3 GPs partners to 1 GP. The patient list was 12, 052 patients, a rise of 1.2% in the last 12 months. The practice were reliant on long term locums to enable them to continue to provide safe care and treatment. At the 	

inspection we were told that there was a salaried GP starting in June 2023 and the possibility of a new GP partner commencing with the practice in Autumn 2023.

Since the inspection, the Lincolnshire Integrated Care Board Quality and Performance team had visited the practice on 31 May 2023 to review the concerns found by CQC and they will be speaking with the practice to put together an action plan and supporting them to make the required improvements over the coming weeks.

Vision and strategy

The practice did not have 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.	No ¹
Staff knew and understood the vision, values and strategy and their role in achieving them.	No ²
Progress against delivery of the strategy was monitored.	No ³
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. The provider had a statement of purpose which did not accurately reflect the staffing arrangements. For example, the registered manager and GP partner was no longer working at the premises and hadn't for a period of 5 months. We found prior to the inspection that the registration of this practice was also an issue. We found that one of the GP partners had retired which left the practice without a registered manager and with one lead GP working alongside salaried and locum GPs. A new registration process was in the early stages and CQC and the Lincolnshire ICB were working with the practice to ensure this was progressed in a timely manner. 2. Staff who completed staff questionnaires told us they were not aware of the vision and strategy of the practice. None had been involved in the strategic planning of the practice. 3. We saw no evidence of the progress of any strategy being monitored. 	

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 ¹
There was a strong emphasis on the safety and well-being of staff.	No ²
There were systems to ensure compliance with the requirements of the duty of candour.	Yes ³
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.	Partial ⁴
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. We received 22 responses from a staff questionnaire and asked, "Is there an opportunity to raise concerns?" We received 22 responses who agreed that they could raise concerns . Most staff who completed the questionnaire and staff we spoke with told us that the practice manager had an open door policy and was approachable and supportive to all staff. We also asked, 'is there an opportunity to raise concerns?'. 18 staff who responded agreed and four disagreed. 2. At the time of our inspection we were told staff from all roles within the practice were affected by workplace stress and that this was due to high workloads because of staffing shortages. A high turnover of staff resulted in at times increased work due to the recruitment and training of new staff members. 3. We reviewed significant events and complaints at the practice and saw in records we reviewed that there was always compliance with the duty of candour and apologies were given. 4. There were gaps in staff training for equality and diversity. Only two GPs had completed this training, 4 out of nine nurses and 13 out of 21 administration staff. 	

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

Source	Feedback
We received feedback from members of the practice team by a series of structured interviews with clinical and non-clinical staff and via returned staff questionnaires.	<ul style="list-style-type: none"> • Most staff who completed the staff questionnaire and took part in staff interviews agreed that the practice team cared about the patients and worked well together as a team to provide safe care and treatment. • There was positivity about practice management arrangements which had been in place for the last 10 months at the time of our inspection. Most said that they appreciated the open-door policy and would if needed go and talk to the practice manager about workload or any other concerns. • In the 22 responses to the CQC questionnaire and in some of the staff interviews, there was a feeling that staff were under great pressure and felt more staff were required in certain areas due to high workloads. This in turn had caused a significant work backlog; lack of protected time to do training; lack of appraisal and supervision; and not all staff knew about the vision for the practice.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No ¹
Staff were clear about their roles and responsibilities.	Partial ²
There were appropriate governance arrangements with third parties.	No ³
There are recovery plans in place to manage backlogs of activity and delays to treatment.	No ⁴
Explanation of any answers and additional evidence: <ol style="list-style-type: none">1. The practice were unaware that some of their systems and processes in place were ineffective. For example, management of patient safety alerts, lack of management of tasks, correspondence, coding and summarisation of patient records. Lack of oversight in clinical supervision and competencies of staff, lack of some processes in relation to safe prescribing and staff training. On the day of the inspection we reviewed minutes from three meetings held in 2022 . The meetings did not have set agendas and minutes were limited. Therefore, it was difficult to identify what had taken place, what actions and learning had been shared and who was responsible for actions and a timeframe.2. From staff questionnaires completed those who responded told us that there was not always clear guidance on roles and responsibilities of staff. Staff also told us that due to staff shortages they could not complete their own workload due to having to train new staff.3. Due to the backlog of correspondence at the practice there was not always appropriate governance arrangements in place with third parties.4. At the time of the inspection, we found that the practice had a backlog of correspondence and tasks on the clinical system which we were told was due to volume of correspondence received along with staff shortages and training of staff.	

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 ¹
There were processes to manage performance.	No ²
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	No ³
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.	No ⁴
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. There were no comprehensive assurance systems in place. For example, we found health and safety concerns relating to the premises where assurance systems had not identified these concerns. 2. Performance was not always managed. We found that most appraisals had been carried out but the practice could not demonstrate the prescribing competence of non-medical prescribers and those in ARR roles. 3. The arrangements in place for identifying and managing risks were ineffective. For example, water temperature monitoring for legionella in clinical rooms was not carried out. Emergency lighting was not in place on all floors of the building. Electricity and Gas safety had not been inspected in a timely manner. Following the inspection the practice provided updates that external companies had been booked to carry out this work within a two-week timeframe. However, we did not see that this was in place prior to the inspection. 4. We found the premises required substantial refurbishment in order to improve the quality of care for patients. Some parts of the building were in a state of disrepair, but the premises has been at the top of estates strategy for Lincs Integrated Care Board (ICB) for past 7 years for a new building. When we contacted the ICB and asked for information on the progress we were told that the ICB were already in discussion with a local council to explore options for a site relocation. The ICB continues to explore options regarding long term accommodation. The ICB also continue to look at options for temporary accommodation to provide additional estate capacity in the interim. 	

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.	No ¹
Performance information was used to hold staff and management to account.	No ²
Staff whose responsibilities included making statutory notifications understood what this entailed.	No ³
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. Data was used to monitor and improve performance in a small number of areas. However, not all areas were considered. 	

2. Staff who dealt with correspondence were not always acting on patient information appropriately. There was a lack of monitoring in regard to the management of data on patients' clinical notes and letters received from secondary services. We could not be assured staff whose responsibilities including making statutory notifications understood what was entailed.

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
Explanation of any answers and additional evidence:	

Engagement with patients, the public, staff and external partners

The practice did not always involve the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes ¹
Staff views were reflected in the planning and delivery of services.	Partial ²
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial ³
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. The practice had recently started a new Patient Participation Group. 9 patients had expressed an interest in joining the group and plans were in place to hold their first meeting to discuss how they took the group forward and ideas on how they could support the practice. 2. Of the 22 responses to the staff questionnaire 19 staff members told us that they were not involved in the planning and delivery of services. 	

3. The practice sought help from other stakeholders in relation to concerns over staff shortages. However, other stakeholders were not aware of the extent of some of the challenges the practice faced.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	No ¹
Learning was shared effectively and used to make improvements.	No ²
Explanation of any answers and additional evidence:	

Examples of continuous learning and improvement

1. At the inspection we were not assured that there was a strong focus on continuous learning and improvement. For example, we found significant gaps in the practice systems and processes such as safeguarding, patient safety alerts, medicines management, risk management, management of long-term conditions and overall governance of the practice. We were told and we saw that staff were not up to date with their training and often did not have time to complete this during work time.
2. There was limited evidence of effective learning and improvement. In the staff questionnaire we asked 'is learning shared effectively' 18 staff members said 'No'.

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.