Care Quality Commission

Inspection Evidence Table

Lakeside Healthcare Partnership (Lakeside Healthcare at Lakeside Surgeries Corby) 1-541823683

Inspection date: 22 May 2019

Date of data download: 18 April 2019

Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe Rating: Good

Safety systems and processes

The practice now had clearer systems, practices and processes in place to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Policies were in place covering adult and child safeguarding.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Policies were accessible to all staff.	Yes
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
Systems were in place to identify vulnerable patients on record.	Yes
There was a risk register of specific patients.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	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	Yes

Safeguarding	Y/N/Partial
workers. to support and protect adults and children at risk of significant harm.	

Explanation of any answers and additional evidence:

During the inspection in November 2018 we found that Lakeside Healthcare Partnership as a provider had their own designated Safeguarding Team who were employed within the partnership from Monday to Friday to cover all aspects of what we found to be well documented protocolised embedded Safeguarding processes to protect both children and adults.

The members of the team were easily contactable during working hours via telephone or the task system on the clinical record system Systm One.

We saw that the system for safeguarding was tried and tested and found to be effective in its delivery. Staff members described the safeguarding system as a unique feature of working for the partnership. Staff felt confident that any potential safeguarding concern identified could be escalated to an expert team in the knowledge that there would be oversight, a thorough investigation by liaising with multi agencies, collation of information and follow up. This alleviated undue pressure and anxiety on clinicians.

The safeguarding team delivered safeguarding training and education to staff to enable them to recognise differences in risk from levels one to four, with additional visual support from detailed laminated A3 posters in all consulting rooms and up to date contact numbers and names to empower prompt referrals.

The safeguarding team gathered relevant information from various sources by having direct links with Health Visiting teams, Midwives, School Nurses, Social services, MASH teams and the Police and linked together family members in order to risk stratify each case.

As a result of gathering this detailed and high-level information we saw evidence of very detailed comprehensive reports having been generated for local safeguarding meetings, Child Protection Conference reports and referrals to MASH. The team organised and attended the monthly safeguarding multi-disciplinary team meetings held at the practice to provide updates and action plans.

Information relating to safeguarding investigations, meetings and reports were found to be easily accessible on the patient medical record via generic Lakeside children and adult safeguarding templates in the clinical tree and contained a chronology of concerns and contacts about a child and their family with updates to appraise clinical staff at the time of consultation.

Records had specific Read codes that were current with alerts, icons, information regarding parental responsibility and family contacts.

We saw evidence that when children were not taken to hospital appointments or appointments for immunisations these were followed up.

Reports for Child Protection Case conferences (CPCC) were sent out in plenty of time to allow attendees to read them beforehand and to date the return rate of reports is 100% and the Lead Safeguarding Nurse attended when applicable.

We saw examples of the safeguarding team dealing with Adult safeguarding concerns complying with The Care Act and Capacity issues as detailed in their educational policy.

Referrals were made in the same way as for children and safeguarding information was accessed via the generic Lakeside Adult safeguarding template. Cases were reviewed in depth with expert

Safeguarding	Y/N/Partial
knowledge and oversight by the lead safeguarding GP who provided feedback to the referrer with a management plan which could include referral to social services. The team were able to link agencies to support patients at risk. The safeguarding team distributed a regular newsletter called “Cautionary Tales” which contained learning points from Serious Case Reviews and Local Safeguarding cases for staff to reflect upon. Staff members we spoke with told us they found the newsletters useful and thought provoking. At this inspection we reviewed safeguarding with the safeguarding lead nurse and we found the system at this location continued to be well documented, protocolised, embedded Safeguarding processes to protect both children and adults.	

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 Public Health England (PHE) guidance and if relevant to role.	Yes
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Staff who required medical indemnity insurance had it in place.	Yes
Explanation of any answers and additional evidence: At the inspection in November 2018 we reviewed staff files and spoke with the Human Resources Lead and found that there was not an effective employee immunisation programme in place and no system to ensure staff who had direct contact with patients were up to date with their routine immunisations. At this inspection we looked at records in relation to the employee immunisation programme and found all staff had been contacted on 29 January 2019 for an update on their immunisation status so that their records could be updated. The management team would then assume the staff member had opted out of this programme if no response was received.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: Corby site : 03/03/2019 Brigstock site: 22/02/2019 Forest Gate site: 11/02/2019	Yes
There was a record of equipment calibration. Date of last calibration: Corby site : September 2018 to March 2019 Brigstock site: 22/02/2019	Yes

Forest Gate site: 11/02/2019	
Risk assessments were in place for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure in place.	Yes
There was a record of fire extinguisher checks. Monthly checks took place at each site and also included fire blankets. Date of last external contractor service: Corby site : June 2018 external. Brigstock site : May 2019 external Forest Gate site : February 2019 external.	Yes
There was a log of fire drills. Date of last drill: Corby site : 17/05/2019 Brigstock site: 17/05/2019 Forest Gate site: 16/05/2019	Yes
There was a record of fire alarm checks. Weekly checks take place at each site. Date of last check: Corby site : External - April 2019. Brigstock site : External -17/5/19 Forest Gate site : External -17/5/19	Yes
Emergency Lighting – checked monthly at each site Corby – external September 2018 Forest Gate – External -January 2019 Brigstock – External -November 2018	Yes
There was a record of fire training for staff. Date of last training: Various	Yes
There were fire marshals in place.	Yes
A fire risk assessment had been completed. Date of completion: All sites - October 2018	Yes
Actions from fire risk assessment were identified and completed.	Yes

Explanation of any answers and additional evidence:

At our inspection in November 2018 we found that although Portable Appliance Testing and calibration checks had been carried out at all sites, some electrical items or pieces of equipment at the branch sites which were not identified as having been tested or calibrated.

- At this inspection we found that all equipment we inspected was identified as having been tested or calibrated as appropriate.

In November 2018 we found that fire risk assessments had been undertaken at the end of October 2018 and actions identified had not been completed. We were told the actions would be added to the risk register to ensure they were completed.

- At this inspection we saw evidence that these had been added to the risk register and all actions had been completed at all sites.

In November 2018 we found that records were not available of fire extinguisher checks relating to Forest Gate branch site, that records of fire drills were not available on the day of our inspection relating to the Brigstock branch site and fire safety checks such as those relating to emergency lighting and fire extinguishers were not being carried out consistently.

- At this inspection we saw evidence of fire safety and fire extinguisher checks having been carried out at all sites. Fire drills had been carried out at all sites in May 2019 and the findings had been acted upon.

There was a maintenance arrangement in place in respect of the lift at the Corby site and it was last serviced on 16 May 2019.

A legionella risk assessment had been undertaken for the Corby site on 27 June 2017 and was due to be renewed in June 2019. All actions had been completed.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: All sites 05/02/2019.	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: All sites - 10 May 2019	Yes

Explanation of any answers and additional evidence:

At our inspection in November 2018 we found that the system for identifying and acting on risks was not consistent across all sites and not all identified risks had been acted upon in a timely way.

- At this inspection we found that a security risk assessment had been carried out at all sites on 5 February 2019 and no actions were outstanding.

We also saw that health and safety risk assessments had been carried out at all sites regularly since our last inspection and where appropriate identified actions were added to the risk register and monitored until they were closed.

The hub manager told us that going forward all their security and health and safety risk assessments would be undertaken by an external contractor.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
An infection risk assessment and policy were in place.	Yes
Staff had received effective training on infection prevention and control.	Yes
Date of last infection prevention and control audit:	Corby site July 2018

	Brigstock site and Forest Gate site January 2019
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
Explanation of any answers and additional evidence: At the inspection in November 2018 we found that the system for infection prevention and control at the Forest Gate surgery was not being operated effectively. An infection control audit had been carried out in April 2018 and actions identified. The audit had been repeated in October 2018 and many actions were still outstanding, for example cluttered surfaces and dusty areas. • At this inspection we reviewed the infection prevention and control systems in place and found that improvements had taken place. We saw that an external audit had been carried out, monthly checks of all areas had been put in place and a quarterly action plan which gave the management team the opportunity to see the priority areas for maintenance and further education if required.	

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
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	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 was a process in the practice for urgent clinical review of such patients.	Yes
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Yes
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Yes
When there were changes to services or staff the practice assessed and monitored the	Yes*

impact on safety.	
Explanation of any answers and additional evidence: At the last inspection in November 2018 as the result of a significant event staff had received sepsis training and the practice had purchased paediatric pulse oximeters in addition to standard pulse oximeters to assist in early identification of potential cases of sepsis. • At this inspection we saw that from 25 March 2019 the practice had commenced a same day service with the primary aim of improving patient access. Within this same day access service, a process of triage was introduced for all face to face consultations. They now used a range of triage tools which included the National Early Warning Score (NEWS)2 which is a scoring system for the identification of acutely ill patients including those with sepsis. They also use the Paediatric Observation Priority Score (POPS) which is a checklist which can quickly score acutely ill children between the ages of 0 to 16 years to aid detection of serious illnesses including sepsis. There was a lead GP available every day which enabled urgent clinician review of deteriorating or acutely unwell patients.	

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
Referral letters contained specific information to allow appropriate and timely referrals.	Yes*
Referrals to specialist services were documented.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes*
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
Explanation of any answers and additional evidence: At this inspection we found that the practice had started to use the web based GP portal tool for referral pathways and relevant forms. It was also used for medicine alternatives and links to new guidelines. We reviewed the approach the practice had in regard to the management of test results and found that at this inspection test results were managed in a timely manner. We found that all urgent test results were dealt with by a GP who was on the rota for the same day access service and we were told that results were also filed on the same day. As a result, we found there was no backlog of results to be reviewed.	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) NHS Business Service Authority - NHSBSA)	0.96	0.97	0.94	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). (01/10/2017 to 30/09/2018) (NHSBSA)	9.9%	8.5%	8.7%	No statistical variation

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 in place 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*
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes*
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and	Yes

Medicines management	Y/N/Partial
written procedures in place for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	
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.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held.	Yes
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Yes
There was medical oxygen and a defibrillator on site and systems were in place to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes

Explanation of any answers and additional evidence:

At our inspection in November 2018 we found that the provider did not act in accordance with national guidelines in respect of prescription security. We found that the system in place did not track prescriptions through the practice, to and through the branch surgeries. Additionally, we found that some rooms which contained prescriptions in the printers were not kept locked.

- At this inspection we found that a new process had been introduced and the provider had rewritten their standard operating procedure (SOP) which related to prescription security and safety. This had been signed by all relevant staff to acknowledge they were aware of the new process and their associated responsibilities. We saw that prescription security had been discussed at meetings and spot checks and audits of the new process had been carried out regularly at all sites. Door locks had also been fitted where required. The new system ensured that prescription stationery was kept securely and monitored by tracking through the practice as well as to and through the branch surgeries.

At the inspection in November 2018 we found that the practice could not demonstrate the prescribing competence of non-medical prescribers, and if there was regular review of their prescribing practice supported by clinical supervision or peer review.

- At this inspection the management team told us that discussions had taken place on a Lakeside Healthcare Group clinical oversight model which would incorporate clinical supervision, prescribing and competence of staff who worked at Lakeside. We spoke with the Chief Nursing Officer who told us a policy was now in place and there was an expectation that each registered nurse, allied health professional and health care assistant would have an allocated mentor, continue to have an annual appraisal alongside facilitated clinical supervisions sessions, complete an audit every three years and take part in local quality and nursing/allied health professional meetings. Those members of the clinical team that took part in the same day/urgent care service would also have an allocated daily supervisor who was responsible for overseeing the delivery of care and who would be available for discussion of any immediate concerns. A template to record clinical supervision developed by another Lakeside Healthcare Group practice had just been put in place. We saw an example of where this template had been used for a discussion with a GP Registrar. This new process had only just been commenced and needed time to be embedded. A formal review of the first three months would take place in July 2019. It

Medicines management	Y/N/Partial

was therefore too early to review a selection of supervision notes for clinical staff who worked at Lakeside at Corby.

At the inspection in November 2018 we found medicines at the Forest Gate Surgery which had exceeded the manufacturers' use by date, despite checks of the medicines having been recorded as having been carried out. The checking process for expiry did not involve physically checking the medicines themselves, only checking the attached stock sheet which did not reflect the contents of the bag. We found expired stock in the emergency bag and some medicines the provider had believed to be present were missing from the bag and could not be located on the premises.

- At this inspection we found that the system for the checking of emergency medicines had changed across all three sites. A new standard operating procedure for emergency response equipment including medication had been put in place for the five emergency bags held across Lakeside at Corby. All emergency bags had a seal on them. Visual checks were carried out daily and a signoff sheet was kept with each bag. Once the emergency bag had been opened, a full check of its contents were carried out by a registered nurse. Each bag had a list of contents together with the expiry dates. We reviewed the contents of the emergency bags at Forest Gate and Brigstock and found all were within their expiry date and benzylpenicillin was available to treat patients with a severe infection. The management team told us that compliance had been a real challenge. They had achieved 100% but would continue to monitor all the bags to ensure this was embedded and maintained.

At the inspection in November 2018 we found that the practice did not have an effective system in place for patients in receipt of warfarin who required regular blood testing had their tests done by a third-party healthcare provider, commissioned by the clinical commission group. The system did not provide the practice with patients' INR result or the date when their next INR test was due. Information was only received directly when a patient had missed a test. The practice was able to see INR results manually through the ICE system (Integrated Clinical Environment) but we found that the practice was not routinely updating the clinical systems to allow prescribers to see results in the practice clinical system. Prescribers were in a position where they prescribed warfarin without being in possession of all the facts to enable them to make a considered, safe judgement.

- At this inspection we reviewed a sample of patient records to demonstrate that high risk medicines were managed appropriately. The practice was engaging with local hospital trusts and the CCG to improve information sharing and adherence to national guidance in the locality. We were told that there were plans to bring the anticoagulant monitoring service in house to ensure clinicians had enough information to support safe prescribing. Following the inspection, we received a detailed plan on the next steps the provider planned to take to further support safe prescribing. It was in its infancy and further discussions were required with the clinical commissioning group to take these plans forward.
- We also found that since the inspection in November 2018 improvements had been made in the safe handling of requests for repeat prescriptions, including high risk medicines. We checked three records for patients who were receiving high risk medicines and found they had all had the required monitoring carried out or the patient had been contacted to chase up outstanding blood tests.

Medicines management	Y/N/Partial
At the inspection in November 2018 we found that incoming correspondence was processed by the administration team and whoever scanned the information in to the system made the decision about who needed to see it. There was no protocol or oversight to check that the system was working correctly. We saw examples where clinical letters relating to changes of medicines had not been sent to the pharmacists for action. Additionally, the pharmacists told us they had a seven to ten-day backlog of letters for medicines changes. They said anything urgent would go to the GPs but it was not clear how the administration team were deciding what was urgent. • At this inspection we saw that there was an improved process for managing clinical correspondence. We were told that the practice received approximately 400 clinical letters per day. We found that there were 180 letters outstanding which dated back to 8 May 2019 but the practice had a plan in place for them to be distributed between the GPs and the clinical pharmacist. We sampled recent correspondence and saw that it was being managed via the new process and the practice was auditing 2% of incoming correspondence received, on a monthly basis, to ensure compliance. At this inspection we looked to see if staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions). The practice had these in place but the signature sheet for each PGD to demonstrate the appropriate staff had signed was not found with the PGD's. We were told that the sheets were kept in the staff personnel files. The lead nurse told us that going forward a copy of the signature's sheets would be kept in the PGD file for information. <u>Controlled drugs</u> See dispensary services section.	

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 was in place to monitor staff compliance.	Yes
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Yes
Prescriptions were signed before medicines were dispensed and handed out to patents. 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	Yes

safe and effective.	
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	N/A
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	N/A
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Yes
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes
Explanation of any answers and other comments on dispensary services: There was a lead GP and the Lakeside group had also appointed a Group Dispensary Lead to oversee processes across their sites. Standard Operating Procedures had been updated to reflect good practice and there was evidence that staff had read them and were working to them. All dispensary staff were now trained to NVQ level 2 and had competence assessments completed annually in line with their roles. All prescriptions were signed before medicines were given to patients (including acute prescriptions)	

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 in last 12 months:	228
Explanation of any answers and additional evidence: Staff at the sites were proactive in reporting significant events and near misses were also recorded in the significant event log in order to also learn from these. We saw that significant events were a fixed agenda item for meetings held for all staff groups. However, we saw that there was no record in nurse meeting minutes or meetings for non-clinical staff in 2019 of discussion of significant events. We were told this was because the practice had used the meetings to focus on areas they had prioritised following our last inspection as well as discussion around the implementation of the new appointment system. We saw that a list of significant events had been compiled for discussion at the June protected learning time meeting. Despite the lack of formal discussion, we did see clear evidence of dissemination and sharing of learning with relevant	

staff groups as a result of significant events.

The hub manager told us they had just appointed a new member of staff whose role was to be responsible for dealing with and monitoring significant events and complaints.

The pharmacy team we spoke with told us that once they had reported a significant event they had no further input and were not aware of the investigation, learning and actions.

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

Event	Specific action taken
Concerns raised internally regarding competence of HCAs carrying out spirometry tests	Clinical oversight of the staff performing the tests was sought and as a result identified that training updates were required. As a precaution, spirometry clinics were suspended and an audit of patients who may have been affected was carried out which identified low risk. Interim internal training was given to the HCAs as well as external training being booked to enable the clinic to be restarted.
Vaccine fridge found with door ajar and possible breach of cold chain.	The fridge was quarantined. Learning was that the standard operating procedure was to remain at each fridge location and a cold chain audit was developed and the template shared.

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
We saw there was a system in place and alerts were actioned. However, medicine recalls that required action within 48hrs were not always received at dispensary quickly enough. The surgery took steps to rectify this during the inspection.	

Effective Rating: Good

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment were 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
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
Appropriate referral pathways were in place 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

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHSBSA)	1.04	1.12	0.81	No statistical variation

Older people Population group rating: Good

Findings
• The practice held a list of vulnerable patients whose frailty risk had been stratified and personalised care plans agreed and put in place. The team met weekly to review patients and appropriate patients were escalated to the monthly Palliative Care multi-disciplinary meeting for discussion. Since the last inspection a member of staff had been appointed as the palliative care lead. • The practice was piloting an extended service to palliative and complex patients whereby they were able to contact a senior receptionist directly who would then assist them with their needs appropriately and in a timely way. • The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. • Staff had appropriate knowledge of treating older people including their psychological, mental

and communication needs.

- Health checks were offered to patients over 75 years of age.
- The practice aimed to provide as much care as locally as possible for patients. A number of GPs had specialist interests and provided specialist clinics for patients who would otherwise have had to travel to community or secondary care providers.
- Services available at the practice and to which patients could be referred included physiotherapy and a local wellbeing clinic.
- The service looked after patients in five local care homes. The practice carried out annual reviews of these patients in the care homes and the reviews were undertaken by a GP, health care assistant and a CCG prescribing advisor. Medicines, mental capacity and Do Not Attempt Resuscitation (DNAR) documentation were reviewed as part of this process.

People with long-term conditions Population group rating: Good

Findings

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. There were nurse-led long term condition clinics for hypertension, asthma and COPD.
- The practice also employed a number of specialist nurses who provided Heart Failure, Diabetic and hypertension clinics. The Heart Failure nurses worked with the local heart failure multi-disciplinary team. The diabetic specialist nurses worked closely with the community and secondary care-based teams to provide personalised treatment plans for these cohorts of patients in a multi-disciplinary approach. They also worked closely with the GPs for those patients who had very complex needs.
- As a result of a significant event some staff had received update training on wound management and diabetic foot assessments.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. For example, as part of the seasonal flu clinics the practice included pulse checks in order to opportunistically screen for undiagnosed atrial fibrillation.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Self blood pressure monitors were also available.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Improvements had been made to the system for repeat prescribing of high risk medicines to patients with long-term conditions such as methotrexate, lithium and warfarin to provide clinical oversight.
- In February 2019 the practice started a low carbohydrate clinic for patients with a long term condition but in particular those with diabetes, hypertension, polycystic ovary disease, non-

alcohol fatty disease. We were told that one patient had already had a good weight loss since starting this clinic.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	89.2%	88.2%	78.8%	No statistical variation
Exception rate (number of exceptions).	26.7% (674)	25.0%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	85.3%	86.3%	77.7%	No statistical variation
Exception rate (number of exceptions).	11.9% (299)	10.3%	9.8%	N/A
	Practice	**CCG average**	**England average**	**England comparison**
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	86.2%	85.7%	80.1%	No statistical variation
Exception rate (number of exceptions).	18.3% (461)	16.9%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	75.9%	75.5%	76.0%	No statistical variation
Exception rate (number of exceptions).	6.8% (173)	4.7%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	93.0%	92.4%	89.7%	No statistical variation
Exception rate (number of exceptions).	13.3% (190)	10.9%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	86.8%	86.3%	82.6%	No statistical variation
Exception rate (number of exceptions).	5.0% (307)	3.9%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	97.9%	96.4%	90.0%	Variation (positive)
Exception rate (number of exceptions).	4.1% (28)	3.6%	6.7%	N/A

Families, children and young people — Population group rating: Good

Findings

- Childhood immunisation uptake rates were higher than the World Health Organisation (WHO) targets.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Young people could access services for sexual health and contraception.
- Travel advice and immunisations were available.
- There was a central safeguarding team who maintained a 100% completion rate on child conference reports.
- Health care assistants at the practice had received training which enabled them to provide smoking cessation services.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three	589	632	93.2%	Met 90% minimum (no variation)

doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018)(NHS England)				
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	592	646	91.6%	Met 90% minimum (no variation)
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) (01/04/2017 to 31/03/2018) (NHS England)	593	646	91.8%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	595	646	92.1%	Met 90% minimum (no variation)

Working age people (including those recently retired and students) — Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. The practice had received recognition locally as an effective referrer into the Pre-Diabetes Program.
- Smoking cessation services were offered by health care assistants at the practice.
- The practice had enrolled as a Royal College of Physicians park run practice. Under this initiative GP practices across the UK are encouraged to develop close links with their local parkrun to promote the health and wellbeing of staff and patients.

Cancer Indicators	Practice	CCG average	England average	England comparison
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) (01/04/2016 to 31/03/2017) (Public Health England)	69.5%	71.1%	72.1%	No statistical variation
Females, 50-70, screened for breast cancer in	75.5%	70.2%	70.3%	N/A

last 36 months (3 year coverage, %) (PHE)				
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE)	55.2%	53.4%	54.6%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (PHE)	49.8%	74.9%	71.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE)	51.4%	55.0%	51.6%	No statistical variation

The practice told us they had taken a number of actions since the inspection in November 2018 to increase the uptake of patients attending for cervical screening. These included active call of non-responders including a focus on those youngest patients eligible who had never had a cervical screening. It was also promoted around the practice and on the practice website.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- 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 held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition. However, the practice had last run the search two years ago and needed to do this more frequently to ensure all relevant vaccinations were offered to those who were eligible. We saw examples of searches completed in the last 12 months which included patients who had had a splenectomy and those patients who had chronic kidney disease.
- The practice demonstrated that they had a system to identify people who misused substances and hosted clinics for this purpose.
- Learning disability health checks were provided and the practice had a learning disability champion.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- There was a system for following up patients who failed to attend for administration of long-term

medication.

- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis and advanced care planning was carried out for patients with dementia.
- Staff had received Mental Capacity Act and awareness training.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	96.1%	95.8%	89.5%	No statistical variation
Exception rate (number of exceptions).	22.0% (51)	20.5%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	96.4%	96.7%	90.0%	No statistical variation
Exception rate (number of exceptions).	16.4% (38)	14.9%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	83.0%	81.0%	83.0%	No statistical variation
Exception rate (number of exceptions).	5.4% (20)	4.7%	6.6%	N/A

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.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	559	-	537.5
Overall QOF exception reporting (all domains)	8.1%	5.7%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes

The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Yes

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

At this inspection we reviewed quality improvement carried out since the last inspection. We saw the audit calendar kept on the shared drive and there was the formalisation of actual audits carried out. Registrars and medical students were also involved in this process :-

- We saw that the clinical team had completed three full cycle audits in relation to antibiotic prescribing. The impact of these three cycles was reduced prescribing and improved documentation of why they were prescribed.
- The practice had carried out a two cycle audit on the prescribing and administration of a medicine used for patients with conditions such as osteoarthritis. They were carried out to check on the blood monitoring, prescribing of further medicines such as Vitamin D and Calcium and referral back to secondary care as required. In March 2019 out of 16 patients, 12 had received an annual review and 13 had a recall in place.
- In February 2019 the practice had carried out an after death audit to review if patients had died in their preferred place of death. 93 deaths had been recorded in the previous three months. 14 sets of patient's notes were reviewed. Out of these notes, five patients had died in their preferred place of death which had been documented in their patient records. Going forward, the practice needed to discuss with clinicians to document a preferred place of death and a further audit would be carried out in three months' time.
- We saw that an audit for the monitoring of a medicine used for patients with an irregular heartbeat which had been discussed at a business meeting on 17 May 2019. Monitoring was in place to ensure it had been initiated in secondary care and was in line with NICE guidance.

Any additional evidence or comments
We saw the practice had an ongoing programme of clinical audits covering a range of areas and range of clinical staff were involved. For example, GP registrars, medical students and going forward nurses and healthcare assistants would complete an audit once every three years as part of the clinical oversight model.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Yes*
The learning and development needs of staff were assessed.	Yes

The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff. This included completion of the Care Certificate for Health Care Assistants employed since April 2015.	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
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

Explanation of any answers and additional evidence:

At the inspection in November 2018 we found that there was no structured review of nurses' clinical decision making. The provider told us and we saw evidence that this was an area that they had identified for action.

At this inspection we spoke with the Chief Nursing Officer who leads on the development of a nursing environment which aims to provide excellence in clinical care. We found she had extensive knowledge of clinical and patient care standards and strove to ensure all clinical staff who worked in the Lakeside Healthcare Partnership had the skills, knowledge and experience to carry out their role.

We also spoke with the Lead Nurse to get an overview of the changes they had made since the last inspection. The lead nurse had been in place for the past 12 months and had provided stability and leadership to the nursing team at Corby. We were told and we saw that a number of changes had taken place. There was now a clinical oversight plan for clinical staff which included the nursing team and allied health professionals. A template developed on another Lakeside Healthcare Group location had been recently implemented to enable supervision to be documented. Internal recruitment for nursing staff had resulted in two practice nurses commencing a course to become nurse practitioners. An external advert for nursing staff was planned which would include the offer of developmental posts for nurses to be trained as nurse practitioners. As a result of three significant events staff had received training and updates on wound management, spirometry and how to carry out a diabetic foot review.

At this inspection we were told that Lakeside Healthcare Partnership had implemented the Care Certificate as a standard for all new health care assistants. The care certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

The practice was working collaboratively with Northamptonshire Health and Care Partnership to attract and retain nurses into a career in General practice. They were taking part in the nurse training post pilot in general practice. it was a brand new training programme which prepared nurses for careers in general practice.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
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
We saw that patients who had been diagnosed cancer patients were sent a letter from the practice with the offer of support, offering them support. A direct dial number was available for them to contact the practice.	

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
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, tackling obesity, social prescribing and low carb clinic.	Yes
The practice had started a new service with diet and lifestyle advice for any patients who would benefit from weight loss. This was in the form of group consultations and took place weekly in the evenings to improve access for patients.	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	94.6%	94.4%	95.1%	No statistical variation

Exception rate (number of exceptions).	1.3% (131)	1.1%	0.8%	N/A

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
The practice monitored the process for seeking consent appropriately.	Yes

Caring Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

CQC comments cards	
Total comments cards received.	17
Number of CQC comments received which were positive about the service.	13
Number of comments cards received which were mixed about the service.	3
Number of CQC comments received which were negative about the service.	1

Source	Feedback
CQC comments cards	The majority of patients who commented were happy with the care and treatment they received from all staff groups. Some commented positively on the new appointment system and staff were described as polite and respectful and patients said they were listened to. The negative comments related to dissatisfaction with the appointment system.
NHS Choices	In the last 12 months there had been nine reviews of the practice on the NHS choices website. Two of these were positive about the service received. The negative comments related to access to the service and were made prior to the implementation of the new appointment system in March 2019.
Friends and Family Test (FFT)	In 2018, 90% of patients who completed the friends and family test were likely or extremely likely to recommend the practice to friends or family. We looked at the family and friends test results (FFT) from December 2018 to March 2019. 1898 patients completed the FFT cards 90% were extremely likely or likely to recommend the practice to family and friends.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
48851	338	112	33.1%	0.23%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	87.4%	88.9%	89.0%	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 (01/01/2018 to 31/03/2018)	87.3%	87.9%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	93.5%	92.8%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	73.3%	76.2%	83.8%	No statistical variation

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

Any additional evidence
Patient feedback received from various sources including NHS Choices, GP patient surveys and complaints was collated and discussed at practice quality meetings and fed in to their quality improvement plan. Access was still an issue but the practice had put in place the same day access service in order to improve the patient experience.

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

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	97.3%	95.6%	93.5%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	707 patients identified as carers which represented 1.4% of practice population.
How the practice supported carers.	The practice had been awarded the Bronze carers award with Northamptonshire Carers. A Carers champion had been appointed to identify and support carers and had taken part in a voluntary pilot with Voiceability supported by the CCG as part of relaunching their carers and learning disability services.

	We could not see a dedicated section on the practice's website that indicated support available to carers and encouraged patients to identify whether they were carers.
How the practice support people who are bereaved	GPs contacted families who had been recently bereaved. A home visit or an appointment was often offered, if required, at a time to suit them. The practice was also able to signpost relatives to other support services where appropriate.

Privacy and dignity

The practice respected respect patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
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

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Yes
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Yes
Explanation of any answers and additional evidence:	

Practice Opening Times	
Day	**Time**
Opening times: **Corby and Forest Gate sites**	
Monday	8.00am to 6.30pm (until 8.00pm at Corby)
Tuesday	8.00am to 6.30pm
Wednesday	8.00am to 6.30pm
Thursday	8.00am to 6.30pm (until 8.00pm at Corby)
Friday	8.00am to 6.30pm
Opening times: **Brigstock site**	
Monday	8:00am to 1.00pm
Tuesday	1.00pm to 6.00pm
Wednesday	8:00am to 1.00pm
Thursday	8:00am to 1.00pm
Friday	8:00am to 1.00pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
48851	338	112	33.1%	0.23%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	96.4%	94.9%	94.8%	No statistical variation

Older people

Population group rating: Requires improvement

Findings

- All 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 had employed a Community Nurse Practitioner who also carried out home visits to improve the continuity of care for complex patients. A second community nurse practitioner had been recruited and was due to start work at the practice in August 2019.
- At the last inspection patients had reported dissatisfaction with access to appointments and to the practice by telephone. This affected all the population groups. The practice had an action plan to address the issues with access and were in the process of implementing this. At this inspection we saw that the practice had commenced a same day service with the primary aim of improving patient access. All patients who wanted to be seen on the same day were offered an appointment.
  However, at the time of our inspection there had not been time to embed the new processes and therefore we were unable to assess the impact.

People with long-term conditions

Population group rating: Requires improvement

Findings

- The practice was progressing work on their recall system to ensure that patients with multiple conditions had their needs reviewed in one appointment to reduce unnecessary visits to the practice.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.

- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.
- The community nurse practitioner saw patients recently discharged after a hospital admission related to their long-term condition.
- Patients with heart failure were able to receive enhanced care to optimise their condition. This was delivered by specially trained nurses with the prescribing qualification to optimise patients' condition and avoid the need to travel to hospital.

At the last inspection patients had reported dissatisfaction with access to appointments and to the practice by telephone. This affected all the population groups. The practice had an action plan to address the issues with access and were in the process of implementing this. At this inspection we saw that the practice had commenced a same day service with the primary aim of improving patient access. All patients who wanted to be seen on the same day were offered an appointment. However, at the time of our inspection there had not been time to embed the new processes and therefore we were unable to assess the impact.

Families, children and young people

Population group rating: Requires improvement

Findings

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- Parents or guardians calling with concerns about a child were offered a same day appointment when necessary as there was a duty doctor available and a daily minor illness clinic.
- The practice offered private areas on request at each of the sites for breastfeeding.
- At the last inspection patients had reported dissatisfaction with access to appointments and to the practice by telephone. This affected all the population groups. The practice had an action plan to address the issues with access and were in the process of implementing this. At this inspection we saw that the practice had commenced a same day service with the primary aim of improving patient access. All patients who wanted to be seen on the same day were offered an appointment. However, at the time of our inspection there had not been time to embed the new processes and therefore we were unable to assess the impact.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

- Patients could book or cancel appointments online and order repeat medication without the need

to attend the surgery. Patients were also able to view results and their records online.

- The main practice was open until 8.00pm on a Monday and Thursday.
- The practice offered minor surgery reducing referrals to secondary care.

At the last inspection patients had reported dissatisfaction with access to appointments and to the practice by telephone. This affected all the population groups. The practice had an action plan to address the issues with access and were in the process of implementing this. At this inspection we saw that the practice had commenced a same day service with the primary aim of improving patient access. All patients who wanted to be seen on the same day were offered an appointment. However, at the time of our inspection there had not been time to embed the new processes and therefore we were unable to assess the impact.

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. Longer appointments were available for patients with learning disabilities or complex issues to enable effective communication.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- Hearing loops were available and patients with a hearing impairment whohad alerts added to their patient record.
- Translation services were available.
- The practice had designed an enhanced support service to help patients whose needs required extra help and support. A dedicated direct dial number to the practice was in place to enable them to access timely support when required.
- At the last inspection patients had reported dissatisfaction with access to appointments and to the practice by telephone. This affected all the population groups. The practice had an action plan to address the issues with access and were in the process of implementing this. At this inspection we saw that the practice had commenced a same day service with the primary aim of improving patient access. All patients who wanted to be seen on the same day were offered an appointment. However, at the time of our inspection there had not been time to embed the new processes and therefore we were unable to assess the impact.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires improvement

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- The practice had plans in place to work with 'Mind Corby' to improve their service and were able to signpost to the Mind Café.
- At the last inspection patients had reported dissatisfaction with access to appointments and to the practice by telephone. This affected all the population groups. The practice had an action plan to address the issues with access and were in the process of implementing this. At this inspection we saw that the practice had commenced a same day service with the primary aim of improving patient access. All patients who wanted to be seen on the same day were offered an appointment. However, at the time of our inspection there had not been time to embed the new processes and therefore we were unable to assess the impact.

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes

Explanation of any answers and additional evidence:

Home visits were triaged by the on-call GP and carried out on a daily basis.

The practice had appointed a Community Nurse Practitioner who also carried out home visits to improve the continuity of care for more at risk patients. A second Community Nurse Practitioner would start at the practice in August 2019.

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)	15.3%	36.5%	70.3%	N/A
The percentage of respondents to the GP patient survey who responded positively to the	37.8%	49.2%	68.6%	Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
overall experience of making an appointment (01/01/2018 to 31/03/2018)				
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	34.1%	44.9%	65.9%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	54.5%	61.1%	74.4%	Variation (negative)

Any additional evidence or comments

At the inspection in November 2018 we found that the practice was fully aware of patient dissatisfaction with access. Following the 2018 GP Survey and 2017 CCG survey which both highlighted issues in getting through to the practice, the practice produced an action plan to address the issues. They had held staff meetings, focus groups and workshops in order to identify the strengths and weaknesses of the current system.

A reception team manager had been appointed who restructured the reception team, improved the induction and training programme for receptionists and set standards and KPI's for the team. There were ongoing plans to further restructure staff working patterns and redesign the call handling model in order to deal with the peaks and troughs of incoming calls. The practice had added a further four incoming telephone lines in July 2018.

The practice had audited capacity and demand and as a result were carrying out ongoing recruitment in order to provide more clinical sessions. They had employed a community nurse practitioner whose role included home visiting with a view to reducing the number of home visits carried out by GPs. An additional Advanced Nurse Practitioner had also been recruited to provide more appointments.

- At this inspection the management team told us that from 25 March 2019 they had started a new same day access service with the primary aim of improving patient access. Patients were now able to request a same day appointment and would be invited to attend a 'sit and wait' clinic. In order for the practice to manage patient flow /surge and ensure safe closing. patients would therefore be asked to attend in blocks of arrival time (e.g. between 1 and 2pm). The practice had also considered that if demand exceeded their capacity then a standard operating procedure, for safe closing, would come into place and patients would be directed to alternative options if they required an urgent review on that day. Following the inspection we were sent evidence of a patient survey which had taken place from 25 March 2019 to 29 April 2019. Of those that responded 79.6% got seen at a time convenient to them and 85% had their problem dealt with on the day. Further monitoring of patient feedback to take place in order for the practice to ensure patient's were happy with the new service provided.

In November 2018 we were told that the practice had also introduced an online system called 'DoctorLink'. This necessitated patients requesting an urgent appointment to undertake an online symptom assessment. If the outcome indicated that an appointment was required, the patient was contacted by the practice to arrange the appointment within a timeframe identified by the online system.

However, at this inspection we found that due to IT issues over the past five months the practice had not been able to progress this on-line system but had plans to continue with this at a later date.

Source	Feedback
NHS Choices	There were nine reviews of the practice on the NHS choices website. Two of these were positive about the service received. The negative comments related to access to the service and were made prior to the implementation of the new appointment system in March 2019.
CQC comments cards	We received 17 comments cards. Of these, three were mixed and one was negative. The majority were positive and patients reported satisfaction with the service they received during their consultations. There were six comments which were positive about the new same day service appointment system but the negative and mixed comments all expressed dissatisfaction with the appointment system.
Family and Friends Testing	We looked at the family and friends test results (FFT) from December 2018 to March 2019. 1898 patients completed the FFT cards 90% were extremely likely or likely to recommend the practice to family and friends. Of the comments that were negative included areas such as availability of appointments, delay at start of the appointment, car parking.

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.	94
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

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
Explanation of any answers and additional evidence: We saw that complaints were a fixed agenda item for meetings held for all staff groups. However, we saw that there was no record in nurse meeting minutes or meetings for non-clinical staff in 2019 of discussion of complaints. We were told this was because the practice had used the meetings to focus on areas they had prioritised following our last inspection as well as discussion around the	

implementation of the new appointment system. We saw that a list of complaints had been compiled for discussion at the June 2019 protected learning time meeting. Despite the lack of formal discussion, we saw evidence of dissemination and sharing of learning within the practice and changes implemented as a result of complaints received. The hub manager told us they had just appointed a new member of staff whose role was to be responsible for dealing with and monitoring complaints and significant events.

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient had complained regarding confusion around when an appointment for a hormone therapy injection was due.	A written apology was given to the patient and, as a result of the complaint, a new template was developed to ensure that patients were contacted appropriately when their next injection was due.
A patient had been given the wrong information about when a contraception injection was due.	A written apology was given to the patient and as a result of the complaint all reception staff were reminded how to calculate when these injections were due. The practice was also looking at changing the system to avoid this happening again.

Well-led Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	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 in place, including a succession plan.	Yes

Explanation of any answers and additional evidence:

At the last inspection we were told that when the practice manager was appointed they carried out a rapid response review of the practice systems and processes to identify any issues and then formulated a quality improvement program to ensure actions were implemented. We saw that the program was being progressed.

At this inspection the Non-Executive Director (NED) and CQC lead GP told us that the practice had gone through a period of change and reflection since the last inspection. The GP partners, senior managers and salaried GPs had attended an away day and were fully engaged in the planned changes and clinical oversight had increased.

We spoke with the Chief Nursing Officer who told us that Lakeside Healthcare Group had invited a small team from Appreciating People, a company who specialised in positive organisational development, to work with them over a number of weeks for a Reflection and Learning Review following the CQC inspection in November 2018. Through a series of sessions, and all staff were invited to attend with an aim to focus on and build on staff strengths. Further aims were to identify and build on the most effective and safe existing working practices and identify key learning from the recent CQC inspection experiences and suggest how to support staff to build in appropriate new measures and changes. This review started in April 2019 and was due to finish by the end of May 2019.

We spoke at length to the lead pharmacist for the group and to the two pharmacists that worked at Corby. They told us that they had not had a role in improving the high risk medicines process or the clinical correspondence management process. They were not aware of how significant event learning was shared or whether the practice had any guidance or protocol for classifying incidents as significant events. We spoke with the NED and the CQC lead GP and looked at meeting minutes where we saw that the pharmacists had been involved in a variety of meetings where significant events had been discussed. The lead pharmacist told us he was implementing a process of data collection to quantify the work of the practice pharmacists but had not started any process of clinical oversight of their work e.g. audit or case review.

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy in place to achieve their priorities.	Yes
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
The Lakeside Partnership Group practice vision was to: • Strive to provide a service based on the core values of care and compassion, best practice, sustainability, integrity, innovation, performance and research. They also had an active interest in medical education, which they believed was an important influence on continuing development and good practice at every level within the practice. At this inspection we saw that there was strong collaboration and support across all staff and a common focus on delivering the strategy and values. The Chief Nursing Officer and Chief Medical Officer met with the Non-executive Director and the management team each month to discuss their quarterly report. These reports were then presented at the Quality Assurance and Governance Management meeting. Each site had its own meeting with staff to cascade information from these meetings. The practice had a 12-point plan which supported the quality assurance and governance system. A template was used to report progress to the management board against the 12 points on a monthly basis. Every quarter the chief nursing officer and chief medical officer visit each of the locations to meet with their management team and go through their 12 point plan. We also saw that Lakeside Healthcare at Corby had a quality improvement plan. We looked at a copy of the plan and found that patient access, health and safety, fire safety, Disease Modifying Ani-Rheumatic Drugs (DMARDS) and high risk medicines, clinical correspondence, nursing team, carers and vulnerable groups, cervical screening rates, infection prevention and control, security all had recommendations in place and the management team where in the process of completing them. The practice placed a strong focus on training, supported by close links with Deaneries and local universities. We saw that Lakeside Healthcare at Corby had an education lead at each site. Additionally, a nurse education lead and senior nurse mentors were in place and the Lakeside Healthcare Group were in the process of developing a nurse/allied health professional education centre. The practice had implemented a same day appointment service in March 2019 as a	

result of patient dissatisfaction with the existing system. They hoped that now the same day access service was in place and patients could be seen on the day of their call the figures would be increase and be more in line with the CCG and national averages. As the service was only implemented in March 2019 they were unsure if the figures would be representative of this new change to patient access. The practice had also installed four further incoming telephone lines to the practice. Following the inspection, we were sent evidence of a patient survey which had taken place from 25 March 2019 to 29 April 2019. Of those that responded 79.6% got seen at a time convenient to them and 85% had their problem dealt with on the day. Further monitoring of patient feedback to take place in order for the practice to ensure patient's were happy with the new service provided.	

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
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The provider had a culture of high-quality sustainable care. Lakeside Healthcare at Corby had an experienced leadership team with the skills, abilities, qualifications and commitment to lead and develop high-quality services. They recognised the training needs of staff at all levels and worked to provide development opportunities for the future of the organisation and sustainable services. They were also aware of the challenges of recruitment and retention and had a strong focus on training in terms of hosting students but also internal training of existing staff to develop their competencies and increase sustainability. We saw examples of this, such as the commitment to upskill the nursing team by offering them an opportunity to become nurse practitioners and advanced nurse practitioners along with ongoing training of Healthcare Assistants in respect of minor illness and long-term conditions.	

At this inspection we gathered further feedback from staff about working within the practice.

Source	Feedback
Staff interviews	Staff said the leadership team proactively asked for their feedback and suggestions about the way the service was delivered. They were particularly positive about the nurse leadership and felt well supported. Staff told us that nurse leaders had an inspiring shared purpose and strived to

	deliver and motivate staff to succeed. Staff said they were supported to develop within their roles, as well as trained to move from into extended clinical roles. For example, from a practice nurse to a nurse practitioner. Staff we spoke with told us that the whole practice worked as a team and that all the GPs and management were very approachable. Staff told us they found it was a supportive environment both clinically and non-clinically. They told us there was a positive team spirit, they liked coming to work and there was never a 'dull moment'.

Governance arrangements

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

	Y/N/Partial
There were effective governance structures and systems in place which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes

Explanation of any answers and additional evidence:
Following the inspection in November 2018 Lakeside Healthcare Partnership were served a warning notice for Regulation 17, Good Governance, under Section 29 of the Health and Social Care Act 2008. The practice was required to be compliant by 31 January 2019.

At this inspection we looked at the systems and processes put in place or improved since November 2018.

We found:-

- The management team had redesigned their meeting structure. The GP partners now met every Friday from 8am to 10am and had an agenda set once week in advance where possible. Due to the time of the meeting it was hoped that all the GP partners could attend so that discussions and decisions could be made quickly when required.
- We reviewed a sample of patient records to demonstrate that high risk medicines were managed appropriately. The practice was engaging with local trusts and the CCG to improve information sharing and adherence to national guidance in the locality. We heard that there were plans to bring the anticoagulant monitoring service in house to ensure clinicians had enough information to support safe prescribing. Following the inspection, we received a detailed plan on the next steps Lakeside at Corby planned to take to further support safe prescribing. It was in its infancy and further discussions were required with the clinical commissioning group to take these plans forward.
- We saw an improved process for the management of clinical correspondence. It was audited, on a monthly basis to ensure compliance.
- We saw an improved process had been put in place for checking of emergency medicines and equipment all the three practices. A new standard operating procedure and daily checking for

emergency response equipment including medication had been put in place for the five emergency bags held across Lakeside at Corby.

- We reviewed the infection prevention and control systems in place and found that improvements had taken place. We saw that an external audit had been carried out, monthly checks of all areas had been put in place and a quarterly action plan which gave the management team the opportunity to see the priority areas for maintenance and further education if required.

We also found :-

- A new process had been introduced for prescription security and safety. The new system ensured that prescription stationery was kept securely and monitored by tracking through the practice as well as to and through the branch surgeries. The provider had also rewritten their standard operating procedure (SOP) in relation to this process.
- A clinical oversight model was now in place which would ensure clinical staff including allied health professionals had a structured review of their decision making.

Managing risks, issues and performance

The practice had clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems in place which were regularly reviewed and improved.	Yes
There were processes in place to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	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:

The provider utilised a 12-point Quality Assurance & Governance Plan to manage activities relating to the safety of the operation including quality improvement. At practice level we were able to see how the 12- point plan was used as the basis for site, management and team quality meetings. The information gathered and monitored in the practice then fed in to the provider's overarching governance framework and risk management systems.

The practice also maintained a risk register which we saw was monitored and which also fed in to the provider's overarching risk register.

- At our inspection in November 2018 we had found that although risk assessments had been carried out, not all actions identified had been acted upon. At this inspection we found that all identified issues had now been actioned. The practice had just appointed an external contractor

to carry out health and safety and premises risk assessments going forwards. We looked at significant event analysis as we saw that there was a number of events in relation to patients with diabetes who had not had regular monitoring. These were reviewed to gain awareness of what could be improved and put a process in place to address the reasons for non-attendance. Going forward there is now a clear process in place for patients who do not attend(DNA) for their annual review. A DNA template was now on the patient record system and the patients GP to complete if the patient had not attended after three invitations had been sent.

Appropriate and accurate information

The practice demonstrated a commitment to act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

Explanation of any answers and additional evidence:

At the inspection in November 2018 we found that prescribers of high risk medicines were not always in possession of accurate and reliable information about patients that enabled them to make safe, considered judgements. This had not been identified as a risk.

- At this inspection we found was an improved process in place 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.

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
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:

We saw examples of changes made as a result of patient feedback. The practice had implemented a same day appointment service in March 2019 as a result of patient dissatisfaction with the existing system. They hoped that now the same day access service was in place and patients could be seen on the day of their call the figures would be increase and be more in line with the CCG and national averages. As the service was only implemented in March 2019 they were unsure if the figures would be representative of this new change to patient access. The practice had also installed four further incoming telephone lines to the practice.

The management team had reviewed the skills of the clinical team and were committed to upskilling their own staff into roles such as nurse practitioner and advanced nurse practitioner.

We saw evidence that nurse meetings had not taken place as regularly as the lead nurse would like due to the implementation of the same day access service. We saw minutes of meetings that had taken place but discussions had not always taken place in regard to significant events, patient safety alerts and complaints. However, these were discussed on a weekly basis by the management team to ensure actions were taken in a timely manner.

The management team told us they had made a decision on their primary care network and paperwork had been submitted prior to the government's deadline date. A primary care network consists of groups of general practices working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations.

Feedback from Patient Participation Group.

Feedback
At our inspection in November 2018 the practice told us that the Patient Participation Group (PPG) was not being fully utilised and was undergoing a review to enable them to speak for the patients and be a link between patients and management team. They told us this was still the case at this inspection and had not been able to focus on this due to having to prioritise actions required following our November 2018 inspection. They told us this was an area for development once new systems and processes recently introduced had been embedded. However, they told us that the PPG had been involved in a patient survey in January 2019, the purpose of which was to assess what patients wanted from the new appointment system. Changes were made to the proposed system on the basis of this feedback. We spoke with a representative of the PPG who also told us that the PPG lacked purpose, direction and support. There was currently no chair and they were not clear on the future of the PPG.

Continuous improvement and innovation

There was 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

The practice was a training practice and had one GP in specialist training (These are fully qualified doctors who have worked at least one year as hospital doctors who work under supervision).

The practice has an education lead who reports to the providers overall lead for education.

The practice is a training practice and takes medical students from Leicester and Cambridge Universities, Nursing students from DeMontfort University as well as registrars.

Pharmacists have recently been employed and work with the GPs with a particular focus on medication changes for patients recently discharged from hospital.

The practice carries out research and the provider's Director for Research and Innovation works with the Non-Executive Directors and the Practice Manager, to assess how research activities can be implemented which complement the core activities of the practice with the aim of improving the quality of the services provided to patients.

The provider operates a 'Best of the best' system to enable implementation at the practice of what is working well at the providers other locations.

Since the last inspection Medical Students had carried out a project on social prescribing. The student would see patients how had social issues and need signposting to external organisations. They researched and put together a leaflet with information on organisations that could help, for example, with health and well-being, finance, disability, dementia and substance misuse.

In February 2019 the practice started a low carbohydrate clinic for patients with a long term condition but in particular, those with diabetes, hypertension, polycystic ovary disease, non- alcohol fatty disease. We were told that one patient had already had a good weight loss since starting this clinic.

As part of the General Practice Forward View published in April 2016 Lakeside Healthcare Partnership at Corby had taken place in the International GP recruitment programme. The programme aims to recruit qualified oversees doctors to practice in England and train as a GP.

The practice was working collaboratively with Northamptonshire Health and Care Partnership to attract and retain nurses into a career in General practice. They were taking part in the nurse training post pilot in General Practice. In the future Lakeside Healthcare Group would like to run its own nurse training education centre.

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 Band	Z-score threshold
1	Significant variation (positive)	Z ≤-3
2	Variation (positive)	-3 < Z ≤ -2
3	No statistical variation	-2 < Z < 2
4	Variation (negative)	2 ≤ Z < 3
5	Significant variation (negative)	Z ≥3
6	No data	Null

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.

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

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease
- **PHE**: Public Health England
- **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.