

# Care Quality Commission

## Inspection Evidence Table

### Lakeside Healthcare at Rushden (1-6017886221)

Inspection date: 11 December 2019

Date of data download: 03 December 2019

## Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

At the inspection in June 2019 we rated the practice as **Inadequate overall** with a rating of inadequate for providing a safe and well-led service. They were placed in special measures for a period of six months and served breaches of regulations for Regulation 12 Safe Care and Treatment and Regulation 17 Good Governance.

At this inspection we found that the management team had made a number of improvements and had achieved compliance for both of the warning notices.

## Safe

## Rating: Good

At this inspection we found that the practice had made improvements to the systems it had in place for patient safety alerts, management of medication reviews and high risk medicines and significant event analysis.

### Safety systems and processes

The practice had clear systems, practices and processes 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
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes

<b>Safeguarding</b>	<b>Y/N/Partial</b>
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
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 workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence:	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
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 if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Explanation of any answers and additional evidence:	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 28/11/19	Yes
There was a record of equipment calibration. Date of last calibration: 28/11/19	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Yearly check – 4/9/19 Date of last check: 3/12/19	Yes
There was a log of fire drills. Date of last drill: 12/6/19	Yes
There was a record of fire alarm checks. New Alarm System fitted November 2019 Date of last check:	Partial <sup>1*</sup>

There was a record of emergency lighting checks. Annual service 4/6/19 Date of last check: 3/12/19	Yes
There was a record of fire training for staff. Date of last training: Various	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 16/1/19	Yes
Actions from fire risk assessment were identified and completed.	Partial <sup>2*</sup>
A legionella risk assessment had been completed. Date of Completion: 20/10/19	Yes
Actions from legionella risk assessment were identified and completed.	No <sup>3*</sup>

Explanation of any answers and additional evidence:

1. Fire alarm checks took place on a weekly basis, however in records we looked we found gaps in the recording from 28 June to 15 July, 11 August to 22 August, 6 September to 16 September 2019.

2. A fire risk assessment was carried out on 16 January 2019. A number of actions were identified, of which not all had been completed on the day of the inspection. For example, fire doors and storage areas infrequently checked. Since the inspection the practice had reviewed the action plan and the majority of actions in relation to fire safety had been completed. Those that were still outstanding had a proposed completion date of 30 March 2020.

3. A legionella risk assessment had been completed on 20 November 2019. Actions had been recommended in regard to the boiler and the hot water temperatures. Since the inspection the practice had completed a legionella action plan. A number of the identified actions still required completion.

We looked at the water temperature monitoring log book carried out by an external company. We found that not all rooms in the practice had been tested each month. We reviewed three months of records and found hot water temperatures were below the Health and Safety Executive recommended level of 50 degrees Celsius.

We spoke with the management team who told us that Lakeside Healthcare Partnership had now changed the external company who would carry out the water temperature monitoring. We also found that in an administration room the practice had had two positive results for legionella. They had sought advice and were required to run the taps within this room for four days and provide a further sample. On the day of the inspection the management team assured us that the room and the taps would not be used until this had been resolved. They would advise the Care Quality Commission when they achieved a negative result and the water temperatures in all rooms were within the limits required by the Health and Safety Executive.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 16/1/19	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 16/1/19	Yes <sup>1*</sup>

Explanation of any answers and additional evidence:

1. The practice had a fire, health and safety action plan. The majority of actions in relation to fire safety had been completed. Those that were still outstanding had a proposed completion date of 30 March 2020.

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met.**

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes <sup>1*</sup>
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 21/11/19	Yes <sup>2*</sup>
The practice had acted on any issues identified in infection prevention and control audits.	Yes <sup>3*</sup>
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>1. The lead nurse for infection control had a good overview of the requirements for infection prevention and control.</p> <p>2. We saw evidence that regular infection control spot checks took place to ensure that all staff maintained the practice standards. Any actions required were completed on the day of the spot check.</p> <p>3. The practice had a programme in place to replace floors that were carpeted to hard floors in non-clinical areas.</p>	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial <sup>1*</sup>
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
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes <sup>2*</sup>
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> <li>1. On the day of the inspection the management team discussed the workforce issues which were currently being experienced at Lakeside at Rushden. They told us that colleagues from Lakeside Healthcare Partnership were providing support on a regular basis, but recent months had been extremely stressful. The Care Quality Commission has asked Lakeside Healthcare Partnership to provide us with regular updates on the level of support being provided to ensure that this did not impact on the safe care and treatment of the patients registered at Lakeside Healthcare at Rushden.</li> <li>2. The practice had recently introduced the Contraceptive Implant Service. They had carried out a patient survey before and after the commencement of this service to ensure it was meeting the needs of the patients registered.</li> </ol>	

## 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 and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes <sup>1*</sup>
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	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
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> <li>1. An investigation processing policy was in place and audits were carried out every three months to check consistency and compliance for the recording and actioning of test results.</li> </ol>	

## Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	1.05	0.95	0.87	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). (01/10/2018 to 30/09/2019) (NHSBSA)	8.6%	7.8%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)	5.66	6.04	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	2.55	2.11	2.08	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 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	Yes

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
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 written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in June 2019 we found the practice did not have an effective system in place for medicines reviews. We found concerns around patients who received medicines had not been reviewed in a timely manner and received regular monitoring in accordance with national guidance. We also found that the practice did not have a clear system for the recall of patients with long term conditions, to ensure they were reviewed in a timely manner.</p> <p>At this inspection we found the practice had prioritised the medication reviews that were outstanding. They had put in place a new system for outstanding reviews and the prescription clerks monitored these on a weekly basis. They had 0.4% of patients registered at the practice who were still due for a medication review. New procedures had been put in place by Lakeside Healthcare Partnership for the recall and monitoring of medicines reviews and we found that these systems were effective which meant that patients health was monitored in a timely manner.</p> <p>At the inspection in June 2019 we found the practice did not have an effective system in place for the management of high risk medicines.</p> <p>At this inspection we found the management team had reviewed and improved the system in place for patients on high risk medicines. We found that the practice conducted regular searches and alerts were placed on the patient record system and records which were reviewed before patients were given repeat prescriptions to ensure that the required blood monitoring or review had taken place.</p>	

Medicines management	Y/N/Partial

## 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 6 months	14
Number of events that required action:	14
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in June 2019 we found the practice did not have an effective system in place to record, investigate and follow up on significant events and complaints. We also found that the process for sharing lessons learnt from significant events and complaints was not effective.</p> <p>At this inspection we found the practice had revised the system for significant events. New documentation had been implemented and there was a dedicated administration lead. Significant events were discussed with the lead GP to ensure clinical oversight and they were discussed at staff meetings. Each significant event analysis had a reference number to enable staff to cross reference with meeting minutes.</p>	

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

Event	Specific action taken
Baby waiting an extended time for a review in a duty clinic.	All babies under one to be offered a same day slot with duty doctor rather than waiting for a triage call.
A prostate specific antigen test (PSA) requested by administration staff without clinical input	All PSA requests to be requested by primary or secondary care clinicians only to ensure that the patient receive the appropriate counselling where required.
Emergency medicine not in emergency bag. Delay in administering medicine to patient	Emergency bag protocol to be embedded with a list of agreed medicines to be contained in emergency bag.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes <sup>1*</sup>



Explanation of any answers and additional evidence:

At the inspection in June 2019 we found the practice did not have an effective system for ensuring that Medicines & Healthcare products Regulatory Agency (MHRA) and patient safety alerts were actioned appropriately.

1. At this inspection found the system for MHRA and patient safety alerts had been improved. All GPs at Lakeside at Rushden were now signed up to receive the alerts. The Lakeside Healthcare Partnership senior clinical pharmacist reviewed all the alerts, determined what actions needed to be taken, carried out the required searches and provided the practice with information for patients. We saw that the alerts were discussed regularly at clinical meetings.

## Effective

## Rating: Requires Improvement

We have rated the practice as requires improvement for providing an effective service because the population groups of long term conditions and working age people (including those recently retired and students) were rated as requires improvement because :-

The percentage of women eligible for cervical screening was below the national average of 80% and the practice did not have a failsafe system in place to ensure that patients had received their results and referred to secondary care where appropriate.

Exception reporting for patients with long term conditions was above the CCG and national averages.

### Effective needs assessment, care and treatment

**Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
Explanation of any answers and additional evidence: Since the last inspection in June 2019 the practice had reviewed and updated standard operating procedures and policies to include NICE guidance. For example, care of the deteriorating patient, hyperkalaemia protocol and blood pressure protocol.	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics	0.88	0.73	0.74	No statistical

Prescribing	Practice performance	CCG average	England average	England comparison
prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>				variation

## Older people

## Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.</li> <li>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.</li> <li>The practice carried out structured annual medication reviews for older patients. At this inspection we found evidence that the practice had prioritised medication reviews that were outstanding. They had put in place a new system for outstanding reviews and the prescription clerks monitored these on a weekly basis.</li> <li>Health checks, including frailty assessments, were offered to patients over 75 years of age.</li> <li>Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.</li> </ul>

## People with long-term conditions

## Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> <li>At the inspection in June 2019 we found that the practice did not have an effective recall system in place for patients who had long term conditions. At this inspection we found that the practice had reviewed the issues with QOF lists and the monitoring of long-term conditions. The practice had identified that a change in clinical system had caused errors in the patient lists for long-term conditions and therefore the searches had not identified all patients. The practice had rectified this at this inspection with updated searches in place and in records we looked at we found that patients that required monitoring were being invited for the appropriate appointment. However, exception reporting in a number of long term conditions was above CCG and national averages.</li> <li>For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.</li> <li>Staff who were responsible for reviews of patients with long-term conditions had received specific training.</li> <li>The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.</li> <li>The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.</li> </ul>

Diabetes Indicators	Practice	CCG	England	England
---------------------	----------	-----	---------	---------

		average	average	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	82.1%	82.6%	79.3%	No statistical variation
Exception rate (number of exceptions).	20.6% (149)	17.5%	12.8%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	84.8%	79.5%	78.1%	No statistical variation
Exception rate (number of exceptions).	14.0% (101)	11.2%	9.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	79.0%	82.2%	81.3%	No statistical variation
Exception rate (number of exceptions).	18.0% (130)	14.6%	12.7%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	77.1%	77.1%	75.9%	No statistical variation
Exception rate (number of exceptions).	10.7% (82)	9.9%	7.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	92.6%	92.4%	89.6%	No statistical variation
Exception rate (number of exceptions).	18.1% (42)	14.9%	11.2%	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 (01/04/2018 to	89.1%	84.6%	83.0%	Tending towards variation (positive)

31/03/2019) (QOF)				
Exception rate (number of exceptions).	7.4% (149)	4.4%	4.0%	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 (01/04/2018 to 31/03/2019) (QOF)	90.1%	93.4%	91.1%	No statistical variation
Exception rate (number of exceptions).	3.0% (6)	4.4%	5.9%	N/A

#### Any additional evidence or comments

At the inspection in June 2019 we asked the practice to review their QOF reporting process to ensure that the management team had clinical oversight.

The practice had put a personalised care adjustment (exception reporting) policy in place which identified the process the practice used when excluding eligible patients from the QOF indicators. We spoke with the management team in regard to exception reporting and they told us that since the last inspection, exception reporting was carried out by the clinical team to ensure it was appropriate and they would undertake a further review at the end of March 2020. Although this was subject of previous reports, on the day of the inspection we felt progress had been made but further work was required to ensure exception figures were reviewed and monitored further.

### Families, children and young people

### Population group rating: Good

#### Findings

- The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for three of four childhood immunisation uptake indicators and the minimum 90% target for one of four childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- 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.
- 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.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus,	132	138	95.7%	Met 95% WHO based target

Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)				
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	133	142	93.7%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	136	142	95.8%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	136	142	95.8%	Met 95% WHO based target

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

## Working age people (including those recently retired and students)

## Population group rating: Requires Improvement

### Findings

- 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.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- 1,692 patients registered at the practice who smoked had been referred/or given treatment to help them to quit smoking in the last 24 months.
- The percentage of women eligible for cervical screening was below the national average of 80% and the practice did not have a failsafe system in place to ensure that patients had received their results and referred to secondary care where appropriate.

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). (31/03/2019 to 30/06/2019) (Public Health England)	73.0%	N/A	80% Target	Below 80% target

Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	78.7%	75.1%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	58.2%	57.0%	58.0%	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. (01/04/2018 to 31/03/2019) (PHE)	60.0%	68.1%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	62.7%	54.1%	53.8%	No statistical variation

### Any additional evidence or comments

We spoke with the management team about their cervical screening process. The practice had a system in place to call patients who required a cervical smear and we could see from meeting minutes we reviewed that cervical screening was discussed. However, in order to improve the attendance for a cervical smear test the practice were currently sending out letters to all females in the two age categories with invitations to attend an appointment for a cervical smear test. In order to improve the cervical screening data the practice had been proactive and were in the process of sending out recall letters to all eligible patients to invite them for a further appointment.

The practice did not have any failsafe actions in place to ensure that cervical screening samples sent from the practice received a documented result or had taken up the opportunity for further tests if required. We spoke with the administration team who told us they would put a process in place to ensure results were received and patients received a referral to secondary care where appropriate.

**People whose circumstances make them vulnerable**

**Population group rating: Good**

### Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. Since the last inspection the practice had been in contact with patients who were asplenic (had their spleen removed) to offer them the appropriate vaccinations and an appointment with a GP to discuss having long term antibiotics.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice had discussed the care and treatment of patients who were going through gender transitioning. Practice staff had seen a video was available by the General Medical Council which

the practice planned to work as a team to agree what support they can offer to patients waiting for appointments at a gender clinic.

**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.
- Same day and longer appointments were offered when required.
- 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.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	91.9%	93.6%	89.4%	No statistical variation
Exception rate (number of exceptions).	16.2% (12)	17.2%	12.3%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	95.2%	94.0%	90.2%	No statistical variation
Exception rate (number of exceptions).	16.2% (12)	13.5%	10.1%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	75.0%	84.6%	83.6%	No statistical variation



Exception rate (number of exceptions).	27.9% (17)	9.0%	6.7%	N/A
--	------------	------	------	-----

## Monitoring care and treatment

The practice had a 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)	558.7	550.4	539.2
Overall QOF score (as a percentage of maximum)	99.9%	98.5%	96.4%
Overall QOF exception reporting (all domains)	8.2%	6.9%	5.9%

	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
Quality improvement activity was targeted at the areas where there were concerns.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

<p>The practice had an audit plan in place. We saw examples of quality improvement which included:-</p> <ul style="list-style-type: none"> <li>A third cycle after death audit which identified that five out of 11 patents had died in their preferred place. These audits were now regularly discussed at multi-disciplinary meetings.</li> <li>A second cycle audit on a medicine used for hypothyroidism to check that it had been appropriately prescribed. The audit found that 10 patients were on this medicine and were appropriately prescribed and risk factors had been discussed.</li> <li>The nursing team had completed an audit for patients who attended with earache. The audit was to check if clinician had prescribed medicines in line with NICE guidance. 100% of patients were given antibiotics against a NICE guideline of 30%. Of those, 85% were given self-care information and 90% given safety netting advice of when to see further help. Learning and actions for the practice were to look at the treatment of patients with earache, what information is given to this category of patients and to make more use of the 'treat your infection' leaflets.</li> </ul>
--

## 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.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Yes <sup>1*</sup>
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 <sup>2*</sup>
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes <sup>3*</sup>
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> <li>1. At the inspection in June 2019 we asked the practice to continue to review the staff training requirements for health care assistants. At this inspection we found that the health care assistant had completed the Care Certificate.</li> <li>2. At the inspection we found the practice had implemented a template for clinical debrief/supervision of their clinical and allied health professional staff used across all Lakeside Healthcare Partnership practices. The template was embedded on the clinical system and enabled the supervisor to support each member of staff. There was a separate template for each team and it was also an effective auditable method of objectively evidencing clinical supervision. Peer reviews took place on a weekly basis at the team meeting.</li> <li>3. At the inspection in June 2019 we found that the practice did not have a system in place when concerns were raised in regard to locum agency staff. At this inspection, we found patient records had been reviewed and whilst patient safety had not been compromised there were lessons to be learnt. The practice had reviewed their process and had introduced a locum pack which included all the required recruitment checks along with an induction and information pack. We were told that clinical oversight of all locums was now carried out by another GP within Lakeside Healthcare Partnership.</li> </ol>	

## 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 (01/04/2018 to 31/03/2019) (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
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes
Explanation of any answers and additional evidence:	

## Helping patients to live healthier lives

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

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

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,	92.3%	94.8%	95.0%	No statistical variation

schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	0.5% (16)	0.8%	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
Explanation of any answers and additional evidence:	

## Caring

**Rating: Good**

### Kindness, respect and compassion

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

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

CQC comments cards	
Total comments cards received.	78
Number of CQC comments received which were positive about the service.	47
Number of comments cards received which were mixed about the service.	5
Number of CQC comments received which were negative about the service.	26

Source	Feedback
CQC Comments Cards – positive comments	Staff caring and treated with dignity Good care and treatment Always receive a good service Receptionists very pleasant Always see children in an emergency
CQC Comments Cards – negative comments	Very long waits for appointments No permanent doctors – too many locums Long wait for repeat prescriptions
NHS Choices	Satisfied patient Poor administration Always found staff to be accommodating Can never get an appointment

### National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
11054.0	291.0	119.0	40.9%	1.08%

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 (01/01/2019 to 31/03/2019)	86.9%	87.6%	88.9%	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 (01/01/2019 to 31/03/2019)	86.1%	86.5%	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 (01/01/2019 to 31/03/2019)	91.9%	94.8%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	79.4%	81.8%	82.9%	No statistical variation

#### Any additional evidence or comments

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

#### Any additional evidence

Family and Friends Testing (FFT)	October 2019 - 417 responses of which 90% were extremely likely or likely to recommend the practice to family and friends.
Patient survey – telephone system	The practice carried out a patient survey in July 2019 in relation to the telephone system. 71% said it was quite or very difficult to get through to the practice by telephone. After the new telephone system had been put in place the practice carried out a further patient survey In September 2019. 82% now found it very or fairly easy to get through by phone. Comments included how it was a much better system, found the text reminder system useful and to be told how many are waiting in the queue to speak to a

	receptionist.
--	---------------

## Involvement in decisions about care and treatment

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

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

Source	Feedback
CQC Comments Cards	Very caring staff and my needs are responded to. Treated with dignity Polite friendly staff Caring and respectful

## 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 (01/01/2019 to 31/03/2019)	90.6%	92.8%	93.4%	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
Explanation of any answers and additional evidence:	

Carers	Narrative
Percentage and number of carers identified.	232 identified which was 2.09% of practice population.
How the practice supported carers (including young carers).	Since the last inspection the practice had identified administration staff who took the lead for carers.
How the practice supported recently bereaved patients.	Since the last inspection the practice had identified administration staff who took the lead for patients who had been bereaved. Due to a complaint the practice had received, staff had received a training session from a local undertaker on how to speak to bereaved relatives, the processes and signposting required to deal with the death of a loved one.
Additional Information:- The practice had focussed on identifying carers since their previous inspection and had increased their number from 0.6% of the practice population in November 2018. The practice had been awarded the Bronze award from the Northamptonshire Carers Association which meant they had submitted evidence that they had improved identification and support to carers registered at the practice.	

## Privacy and dignity

### The practice respected 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*
Explanation of any answers and additional evidence: It was not always possible to maintain confidentiality at the reception desk but staff were able to use a private room if a patient required it.	



# Responsive

# Rating: Good

## Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Partial*
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence: We looked at the appointment system and found that GP appointments could be booked three weeks in advance and nurse appointments 28 days in advance. However, we were told by staff that it was becoming increasingly difficult due to the lack of clinical staff. Lakeside Healthcare Partnership were supporting the practice to provide care and treatment for patients by additional clinical staff attending the practice to undertake clinical sessions where required.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Extended Hours Appointments	
Additional pre-bookable and telephone appointments are offered on two Saturday mornings per month.	
GP Extended Access Appointments	
The practice offered extended access for evening and weekend appointments via the East Northants Hub. Appointments could be booked	

	<p>via the practice. The extended hours access appointments were provided by GPs, Practice Nurses, Paediatric Nurses and other clinicians both inside and outside of core General Practice opening hours in East Northants.</p> <p>Opening times are:</p> <ul style="list-style-type: none"> <li>• 6.30pm to 8pm Monday to Friday</li> <li>• 8am to 12 midday Saturdays</li> <li>• 8am to 12 midday Bank Holidays</li> </ul> <p>All appointments were accessed at Harborough Field Surgery, 160 Newton Road, Rushden. NN10 0GP</p>
--	--

## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
11054.0	291.0	119.0	40.9%	1.08%

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 (01/01/2019 to 31/03/2019)	96.1%	94.3%	94.5%	No statistical variation
<p>The practice had in place an action plan which addressed the areas of the national GP patient survey that were below the CCG average. The management team told us that they had already completed a number of actions, for example, installed a new telephone system, encouraged more patients to register to use online services and advertised the extended access hub which provided additional appointments.</p> <p>In relation to seeing a preferred member of staff was an ongoing issue due to the high turnover of staff. Lakeside Healthcare Partnership were supporting the practice to stabilise the clinical workforce.</p>				

Any additional evidence or comments

## Older people

## Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>• All patients had a named GP who supported them in whatever setting they lived.</li> <li>• 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.</li> </ul>

- The practice provided effective care coordination to enable older patients to access appropriate services.
- The practice had dedicated lead staff for patients who were carers and for those who had suffered a bereavement.
- The practice held a health and well-being event on 12 June 2019 where guest speakers included Age UK, British Legion and Northamptonshire Carers.

### **People with long-term conditions**

**Population group rating: Good**

#### **Findings**

- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- 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.

### **Families, children and young people**

**Population group rating: Good**

#### **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.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Appointments outside of school hours and on Saturday mornings were available.

### **Working age people (including those recently retired and students)**

**Population group rating: Good**

#### **Findings**

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Patients could request repeat prescriptions using the online service
- The on-line service enabled patients to book appointments.
- A flexible appointments system offered face to face or telephone consultations where appropriate.
- Patients could access telephone consultations and appointments on Saturday mornings twice a month.
- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available Saturday

and Sunday at Harborough Fields Surgery.

- Appointments for cervical screening were offered on a Saturday to reduce the delays currently being experienced by patients registered at the practice.

## People whose circumstances make them vulnerable

Population group rating: Good

### Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice had dedicated lead staff for patients who circumstances make them vulnerable.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

## People experiencing poor mental health (including people with dementia)

Population group rating: Good

### Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- The practice had dedicated lead staff for patients who experienced poor mental health.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

## Timely access to the service

### People were 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 <sup>1*</sup>
Appointments, care and treatment were only cancelled or delayed when absolutely	Yes

necessary.	
<p>Explanation of any answers and additional evidence:</p> <p>1. The practice had a home visit protocol. Requests were reviewed by a clinician on a daily basis. Staff we spoke with and comments cards we reviewed told us that the time slots for routine appointments such as dressing changes and the review of long-term conditions had been reduced by Lakeside Healthcare Partnership and they did not feel listened to when they expressed their concerns. We discussed this at the inspection feedback session and were told that the changes to appointment time slots had been put in place by Lakeside Healthcare Partnership and the comments would be discussed with them at the next executive board meeting.</p>	

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 (01/01/2019 to 31/03/2019)	59.4%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	63.5%	65.9%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	58.9%	63.8%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	67.9%	74.3%	73.6%	No statistical variation

Any additional evidence or comments
The practice had in place an action plan which addressed the areas of the national GP patient survey that were below the CCG average. The management team told us that they had already completed a number of actions, for example, installed a new telephone system, encouraged more patients to register to use online services and advertised the extended access hub which provided additional appointments.

Source	Feedback
NHS Choices	<p>Satisfied patient</p> <p>Poor administration</p> <p>Always found staff to be accommodating</p> <p>Can never get an appointment</p>

## 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 six months.	9
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	9
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: At the inspection in June 2019 we found the practice did not have an effective system in place to record, investigate and follow up complaints. We also found that the process for sharing lessons learnt from complaints was not effective.  At this inspection we found that the practice had revised their system for complaints. We found that a clear audit trail had been introduced and there was a dedicated administration lead. Complaints were discussed with the lead GP to ensure clinical oversight and they were discussed at staff meetings. Each complaint had a reference number to enable staff to cross reference with meeting minutes.	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient requested medication via on-line service.	Clinical team to ensure they reauthorise and issue prescription at the same time to avoid a delay.
Patient had not received results of a test requested by a multi-disciplinary team.	Practice reviewed complaint and discussed with the multi-disciplinary team that when they request a test that they ensure they contact the patient to provide feedback.

## Well-led Rating: Good

At the inspection in June 2019 we found that the practice did not provide a well-led service. They were rated as Inadequate overall with a rating of inadequate for providing a well-led service. They were placed in special measures for a period of six months and served warning notices for Regulation 12 Safe Care and Treatment and Regulation 17 Good Governance.

At this inspection we found that the management team had made a number of improvements and had achieved compliance for both of the warning notices. They are now rated as Good for providing a well-led service.

### Leadership capacity and capability

**There was compassionate, inclusive and effective leadership but workforce issues remained a challenge.**

	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 <sup>1</sup>
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	No <sup>2</sup>
<p>Explanation of any answers and additional evidence:</p> <p>Lakeside Healthcare at Rushden is part of the Lakeside Healthcare Partnership Group (LHPG) which has eight locations registered with the Care Quality Commission and serves over 180,000 patients in the counties of Northamptonshire, Lincolnshire, Cambridgeshire and Peterborough. Each location of Lakeside Healthcare Partnership Group (LHPG) has a non-executive director who attends the executive board of LHPG where strategic planning, clinical standards and other regulatory matters were discussed on a monthly basis.</p> <p>At the inspection in June 2019 we had concerns in regard to the clinical oversight of the practice. After the practice was put into special measure the management team took the time to review all the areas of concern and planned on how they would improve over a period of six months.</p> <p>At this inspection, we acknowledged that the practice had begun to make the required improvements. We saw that they had reviewed and updated a number of systems in the practice, for example, locum oversight, significant events and complaints process, mentor system for the nurse team and compliance checks on documentation for both GPs and nursing team.</p> <p>At the time of the inspection the practice did not have a registered manager in place. Due to changes in the management team, a new application had been commenced on 1 November 2019, but the process had still not been completed on the day of the inspection.</p> <p>On the day of the inspection the management team discussed the workforce issues which were currently being experienced at Lakeside at Rushden. Maintaining the current service was described as challenging. A further GP partner was due to leave the practice at the end of March 2020. Members of the nursing team were also leaving over the next four weeks. They told us that colleagues from Lakeside Healthcare Partnership were providing support on a regular basis, but recent months had</p>	

been extremely stressful.

## Vision and strategy

**The practice had a clear vision which was supported by a 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 to achieve their priorities.	Yes <sup>1*</sup>
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: 1. Lakeside Healthcare Partnership vision was 'A Caring Partnership for Life'. They had a set of core values with included care and compassion, best practice, sustainability, Integrity, innovation, performance and research. 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 visited each of the locations to meet with their management team and go through their 12 point plan.	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes



The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence:	

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

Source	Feedback
Practice Manager	Regular one to one meetings with staff and debrief sessions.

## Governance arrangements

### Some governance arrangements required strengthening.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes <sup>1*</sup>
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:	
<p>At the inspection in June 2019 we found that some of the governance arrangements in place were not effective. We served the practice with two warning notices for Regulations 12, Safe Care and Treatment and Regulation 17, Good Governance under Section 29 of the Health and Social Care Act 2008. The practice was required to be compliant by 6 September 2019.</p> <p>We found:-</p> <p>We saw an improved process for the management of MHRA and patient safety alerts. The Lakeside Healthcare Partnership senior clinical pharmacist reviewed all the alerts, determined what actions needed to be taken, carried out the required searches and provided the practice with information for patients. However, we discussed at the inspection feedback that this process required senior clinical oversight to ensure that all patient risk factors were picked up and dealt with appropriately. For example, in a one patient record we reviewed it was documented that a patient did not have cardiovascular risk factors when a review of the records detailed several indicators, such as hypertension and on a cholesterol medicine which suggested they did have a cardiovascular risk. We saw that the alerts were discussed regularly at clinical meetings.</p> <p>We reviewed a sample of patient records to demonstrate that high risk medicines were managed appropriately.</p> <p>We looked at the recall system and found that the practice had prioritised the medication reviews that were outstanding. The practice had reviewed the issues with QOF lists and the monitoring of long term conditions. They found that due to a change of patient record system from EmisWeb to System1, the</p>	

record searches had not transferred to the new system. Searches were now in place

We saw that the practice had revised the system in place for significant events. Each SEA had a reference number to enable staff to cross reference with meeting minutes. Significant events were discussed with the lead GP to ensure clinical oversight and they were discussed at staff meetings.

We saw that the practice had revised the system in place for complaints. Each complaint had a reference number to enable staff to cross reference with meeting minutes. Complaints were discussed with the lead GP to ensure clinical oversight and they were discussed at staff meetings.

The management team had reviewed its meeting structure. GP meetings now took place weekly for 2.5 hours which enabled them to discuss both clinical and business matters. The practice had a flow chart and task list with responsibilities listed to individuals. In the clinical meeting. Meeting minutes we looked at demonstrated an improvement and provided information, actions and learning to staff.

We also found :-

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.

We saw that the lead GP had produced a clinical information folder which could be found in each of the clinical rooms which provided information for all clinical staff such as sharing best practice guidelines, referral pathways, flow charts and local telephone numbers.

However, not all the systems and processes were operated effectively. For example:-

MHRA patient safety alert system required further work to ensure all patient risk factors were identified.

Risks were assessed but not all the actions required had been completed. For example, legionella and fire safety.

Exception reporting required further monitoring in line with the new personal adjustment (exception reporting) policy.

Further monitoring was required for patients who required a cervical smear to ensure women between the ages of 25 and 64 were offered an appointment and a system put in place to ensure results were received and referrals made where appropriate.

## Managing risks, issues and performance

### There were processes in place for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes <sup>1</sup>
There were processes 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.	Partial <sup>2</sup>

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
<p>Explanation of any answers and additional evidence</p> <p>1. At the inspections in November 2018 and June 2019 we found that the practice had little oversight of the high exception reporting for QOF clinical indicators. Searches were now in place and the practice felt confident that all patients that required monitoring were being invited for the appropriate appointment. The practice had also put a personalised care adjustment (exception reporting) policy in place which identified the process the practice used when excluding eligible patients from the QOF indicators. We spoke with the management team in regard to exception reporting and they told us that since the last inspection exception reporting was carried out by the clinical team to ensure it was appropriate and they would undertake a further review at the end of March 2020.</p> <p>The practice maintained a risk register which we saw was monitored and was fed in to the provider's overarching risk register. At the inspection we had found that although risk assessments had been carried out, not all actions identified had been acted upon, for example, install a new gas boiler, legionella and fire safety.</p>	

### Appropriate and accurate information

#### The practice did not always 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
<p>Explanation of any answers and additional evidence:</p> <p>The practice maintained a risk register which we saw was monitored and which also fed in to the provider's overarching risk register. At the inspection we had found that although risk assessments had been carried out, not all actions identified had been acted upon. for example, install a new gas boiler, legionella and fire safety.</p>	

### 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
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had altered the schedules of all the clinicians so that both GPs and nursing team could have joint breaks during the day. Changes to the staff room meant staff were all able to sit in one room.</p> <p>There was now a “You said- We did” board in Reception with examples of where specific feedback from patients has been actioned.</p> <p>The practice produced a quarterly newsletter to keep patients updated on changes within the locality and the practice. For example, improvements to the telephone system, new staff uniforms, pneumococcal immunisations and how to stay well this winter.</p> <p>Within the staff room there was a practice news board and we saw it held information for staff and was also used to congratulate staff on training completed or for the work carried out over the previous month.</p>	

#### Feedback from Staff

Feedback
<p>Staff we spoke with told us that they did not feel supported and morale in the practice was at an all-time low. We also saw minutes of a meeting that took place on 2 August 2019 with the Lakeside Healthcare Partnership in which concerns and morale were raised. Due to the lack of GP appointments the nurse team were under increased pressure and had also had a reduction in the length of their appointments from 30 minutes to 20 minutes to give more availability and this was the reason why staff were leaving. Whilst Lakeside Healthcare Partnership was providing extra clinical support, the length of appointment times remained the same.</p>

#### Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence:	

Examples of continuous learning and improvement
<ul style="list-style-type: none"> <li>New telephone system in response to complaints about patients being able to access the practice by telephone</li> </ul>

- Allocated members of staff for various population groups, for example, carers, bereaved, dementia, learning disability and mental health.
- Improved management of patients who attend with a potential deep vein thrombosis (DVT). A D-Dimer machine was purchased to enable a diagnosis whilst the patient is at the practice, introduction of a DVT protocol with a simple flow chart for clinicians to use for best practice in DVT management.

## Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> 1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

## Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **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.