

# Care Quality Commission

## Inspection Evidence Table

### Beacon Medical Practice (1-591810663)

Inspection date: 20 November 2019

Date of data download: 18 November 2019

## Overall rating: Inadequate

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

## Safe

## Rating: Inadequate

We rated the provider as inadequate for providing safe services.

This was because:

- The practice did not have clear systems and processes to keep patients safe.
- The practice did not have appropriate systems in place for the safe management of medicines.

### Safety systems and processes

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

| Safeguarding   | Y/N/Partial |
|--|-------------|
| There was a lead member of staff for safeguarding processes and procedures.                          | Yes (1)     |
| 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         |
| 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         |

| <b>Safeguarding</b>  | <b>Y/N/Partial</b> |
|--|--------------------|
| 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                |
| (1) The safeguarding policy did not name the lead GP   |                    |

| <b>Recruitment systems</b>   | <b>Y/N/Partial</b> |
|--|--------------------|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).  | No (1)             |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.  | No (2)             |
| There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.  | No (3)             |
| Explanation of any answers and additional evidence:  |                    |
| (1) The two clinical pharmacists used by the provider resided in and worked from Spain. The practice could not produce any assurances that they were fit and proper persons as they did not have an equivalent to a DBS from their home country. They did have DBS evidence from the UK. The recruitment checks for the two clinical pharmacists were inappropriate. Both had only one reference which had been supplied by one of the partners of the Beacon Medical Practice. The provider did not hold any details of the pharmacists' current professional indemnity. The records showed that their indemnity expired on 7 and 8 November 2018 respectively. |                    |
| (2) The records relating to staff vaccinations were incomplete.  |                    |
| (3) The provider did not hold a record of the two pharmacists' current professional registration with the General Pharmaceutical Council. The last recorded registrations had expired on 31 December 2018. There was no evidence of their registration with their professional body in Spain.  |                    |

| <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.<br>Date of last inspection/test: | Yes<br>Dec 18      |
| There was a record of equipment calibration.<br>Date of last calibration:   | Yes<br>May 19      |
| 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.<br>Date of last check:   | Yes<br>Feb 19   |
| There was a log of fire drills.<br>Date of last drill:                   | Yes<br>March 19 |
| There was a record of fire alarm checks.<br>Date of last check:          | Yes<br>Nov 19   |
| There was a record of fire training for staff.<br>Date of last training: | Yes             |
| There were fire marshals.  | Yes             |
| A fire risk assessment had been completed.<br>Date of completion:        | Yes<br>Feb 19   |
| Actions from fire risk assessment were identified and completed.         | Yes             |

| <b>Health and safety</b>   | <b>Y/N/Partial</b> |
|--|--------------------|
| Premises/security risk assessment had been carried out.<br>Date of last assessment:                                | Yes<br>Feb 19      |
| Health and safety risk assessments had been carried out and appropriate actions taken.<br>Date of last assessment: | Yes<br>Feb 19      |

### **Infection prevention and control**

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

|   | <b>Y/N/Partial</b>   |
|---|--|
| There was an infection risk assessment and policy.  | Yes  |
| Staff had received effective training on infection prevention and control.  | Partial (1)  |
| Infection prevention and control audits were carried out.<br>Date of last infection prevention and control audit:   | Yes<br>Skegness<br>April 19<br>Ingoldmells<br>March 19<br>Chapel<br>May 19 |
| The practice had acted on any issues identified in infection prevention and control audits.   | Yes  |
| 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  |
| Explanation of any answers and additional evidence:<br>(1) The provider had no record of any of the GP partners having completed infection prevention and |  |

control training. Following our inspection, we were provided with evidence that all but two had completed the training.

## Risks to patients

### There were gaps in 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.  | No (1)      |
| There was an effective induction system for temporary staff tailored to their role.   | Yes         |
| Comprehensive risk assessments were carried out for patients.   | No          |
| Risk management plans for patients were developed in line with national guidance.   | No          |
| The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.                    | No (2)      |
| Clinicians knew how to identify and manage patients with severe infections including sepsis.  | No (3)      |
| 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. | No (4)      |
| There was a process in the practice for urgent clinical review of such patients.  | No (5)      |
| When there were changes to services or staff the practice assessed and monitored the impact on safety.  | No (6)      |

#### Explanation of any answers and additional evidence:

- (1) We looked at three weeks of appointments chosen at random. In the week 23 to 27 September we saw that of the six partners and two salaried GPs, three had been on annual leave for the whole of that week. No alternative GP clinical appointments had been provided.
- (2) At the Skegness site there was no pulse oximeter on the emergency trolley. Staff were unable to tell us where it was.
- (3) There was no record of any training regarding sepsis. The Registered Manager told us they did not consider it necessary as it formed part of every clinician's training when becoming a doctor or nurse. Non-clinical staff had received no training.
- (4) The practice had not provided any training to staff in recognising sepsis and there was no information available other than some leaflets for patients at the Ingoldmells branch. Staff we spoke with told us that they had an emergency button to press if somebody collapsed which would summon help.
- (5) The practice operated a sit and wait appointment system at all three sites. When all appointments for the day had been filled they put up a notice to that effect and an automated telephone message conveyed the same information to patients. We asked staff what they would do when somebody came into the practice who was un-well and all appointments were taken and were told patients were informed to go to the urgent care centre or try for an appointment the next day. There was also an extended hours hub that operated from the Ingoldmells branch surgery. Receptionists told us they would try and arrange an appointment in that. When asked how they could ascertain if a patient needed to be seen that day, they were unable to provide a coherent answer as they had not received any training and there were no protocols in place. This applied to parents/carers with unwell children, although a receptionist told us that the nurse practitioners would normally try and add some extras at the end of their session if it was deemed urgent. We were unable to ascertain how a case was deemed to be urgent other than when it required an immediate response, such as in the case of collapse.

(6) The potential impact on patient safety because of changes to staffing and a reduction in appointment availability had not been assessed.

## Information to deliver safe care and treatment

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

|  | Y/N/Partial |
|--|-------------|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.  | No (1)      |
| 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         |
| 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> <p>(1) We were made aware that an entry in a patient record was inaccurate and recorded that a patient had attended the practice and received a flu vaccination when this was not the case. We were informed the matter had been brought to the attention of the practice management team. The provider was unable to tell us what action, if any had been taken.</p> |             |

## Appropriate and safe use of medicines

**The practice did not have 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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA) | 0.99     | 1.06        | 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).       | 8.8%     | 10.7%       | 8.6%            | No statistical variation |

| Indicator   | Practice | CCG average | England average | England comparison       |
|---|----------|-------------|-----------------|--------------------------|
| (01/07/2018 to 30/06/2019) (NHSBSA)   |          |             |                 |                          |
| 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 (01/01/2019 to 30/06/2019)<br>(NHSBSA) | 7.02     | 6.30        | 5.63            | Variation (negative)     |
| Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019)<br>(NHSBSA)   | 2.05     | 2.37        | 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).  | No (1)      |
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.   | No (2)      |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.  | No (3)      |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.  | 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.                  | No (4)      |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).  | No (2)      |
| 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. | Yes         |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.  | Yes         |

| <b>Medicines management</b>  | <b>Y/N/Partial</b> |
|--|--------------------|
| 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.  | No (5)             |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.   | No                 |
| 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>(1) We saw an example of a flu vaccination being administered by a health care assistant without there being a patient specific direction in place.</p> <p>(2) Staff we spoke with told us there was no oversight, supervision or review of the competence of non-medical prescribers. When we asked the Registered Manager about this, they replied that as independent prescribers there was no requirement for any supervision, review or oversight of their prescribing practice.</p> <p>(3) We were not assured that medicines reviews were being conducted by the appropriate people. We saw one patient in receipt of warfarin had their medication review completed by a health care assistant. We asked the provider to complete a thorough audit of this health care assistant's practice.</p> <p>(4) Seven patients were in receipt of lithium. One of those patients had received no monitoring since December 2017. It was recorded that six attempts had been made to contact the patient but there had been no response. Nevertheless, the provider had continued to prescribe the medicine. The practice managed patients in receipt of anticoagulants with the assistance of software that did not interface with their clinical system. This resulted in GP prescribing warfarin without being in possession of the latest test results relating to the patient. Partners told us they relied upon being told patients were in therapeutic range, although they did not view the actual results. We also noted that some patients on high risk medicines were on repeat prescriptions for a year. This posed a potential risk if the patient did not attend for regular monitoring.</p> <p>(5) At the Skegness site intrauterine contraceptive devices were fitted. However, the practice did not hold atropine for use in a medical emergency associated with this activity. In addition, at the Skegness site the provider did not have the emergency medicines benzylpenicillin and dexamethasone and/or prednisolone. There was no risk assessment as to why these medicines were not available.</p> |                    |

| <b>Dispensary services (where the practice provided a dispensary service)</b>   | <b>Y/N/Partial</b> |
|---|--------------------|
| There was a GP responsible for providing effective leadership for the dispensary.   | Yes                |
| The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.    | Yes                |
| Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.  | Yes                |
| Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions. | Yes                |



|  |     |
|--|-----|
| Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.   | Yes |
| Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.   | Yes |
| 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. | Yes |
| If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.  | Yes |
| 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 |

### Track record on safety and lessons learned and improvements made

**The practice did not always learn and make 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:   | 16          |
| Number of events that required action:   | 16          |
| Explanation of any answers and additional evidence:<br>Significant events had been well recorded with good evidence collection, outcomes and learning points where appropriate. However, we were made aware that the incident involving a member of staff completing an incorrect entry into a patient record had not been recorded or investigated. |             |

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

| Event  | Specific action taken   |
|--|---|
| Blood stained needle and cotton wool found in recycling bin by cleaner                           | Communication issued to all staff reminding them of correct bin protocol            |
| Antibiotics prescribed although it was documented that patient had an allergy to this medication | Communication to all prescribers to take more care with sensitivities and allergies |

| 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         |

## Effective

## Rating: Inadequate

We rated the provider as inadequate for providing effective services.

This was because:

- Patients with some long-term conditions were not having their health care needs met.
- Cervical cancer screening uptake was below target.
- The practice had high numbers of patients who attended A&E services and high numbers of unplanned admissions to secondary care. The provider had not taken any action to address these issues.

The areas of concern affected all population groups, so we rated all population groups as inadequate.

### Effective needs assessment, care and treatment

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

|  | Y/N/Partial |
|--|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice.                             | 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  | No (1)      |

|  |        |
|--|--------|
| in a timely and appropriate way.   |        |
| We saw no evidence of discrimination when staff made care and treatment decisions.   | Yes    |
| Patients' treatment was regularly reviewed and updated.  | No (2) |
| 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.   | No     |
| The practice used digital services securely and effectively and conformed to relevant digital and information security standards.  | N/A    |
| <p>Explanation of any answers and additional evidence:</p> <p>(1) There was no effective process that reception staff followed, and no training had been provided to staff to help identify and appropriately prioritise and deal with unwell patients, for example those that might present with sepsis.</p> <p>(2) The Registered Manager told us that there was only one chronic disease nurse who had been absent from the practice for some time and as result QOF performance figures had been adversely affected.</p> |        |

| 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) (01/07/2018 to 30/06/2019) <small>(NHSBSA)</small> | 0.87                 | 1.29        | 0.75            | No statistical variation |

## Older people

## Population group rating: Inadequate

| Findings  |
|---|
| <ul style="list-style-type: none"> <li>Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.</li> <li>Patients aged over 75 were invited for a health check. If necessary, they were referred to other services such as voluntary services.</li> <li>The practice did not follow up on patients discharged from hospital unless the discharging hospital requested it.</li> </ul> |

## People with long-term conditions

## Population group rating: Inadequate

### Findings

- The partners told the inspection team that they experienced acute difficulties in recruiting suitable staff to manage patients with long term conditions. As a result, QOF achievement was lower than CCG and national averages for patients in this group.
- For the asthma and COPD indicators they showed significant negative variation.
- Health checks were offered for patients with long-term conditions.

| 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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>                        | 69.7%     | 79.6%       | 79.3%           | Tending towards variation (negative) |
| Exception rate (number of exceptions).  | 2.8% (63) | 9.0%        | 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> | 75.9%     | 78.9%       | 78.1%           | No statistical variation             |
| Exception rate (number of exceptions).  | 4.3% (97) | 6.9%        | 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> | 69.4%      | 81.4%       | 81.3%           | Variation (negative) |
| Exception rate (number of exceptions).   | 9.8% (219) | 12.8%       | 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> | 53.0%     | 76.1%       | 75.9%           | Significant Variation (negative) |
| Exception rate (number of exceptions).   | 1.9% (31) | 9.9%        | 7.4%            | N/A                              |
| The percentage of patients with COPD who have had a review, undertaken by a  | 57.2%     | 83.9%       | 89.6%           | Significant Variation            |

|   |           |       |       |            |
|---|-----------|-------|-------|------------|
| 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) <sup>(QOF)</sup> |           |       |       | (negative) |
| Exception rate (number of exceptions).  | 2.0% (21) | 10.5% | 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 31/03/2019) <sup>(QOF)</sup>   | 77.8%     | 83.2%       | 83.0%           | No statistical variation |
| Exception rate (number of exceptions).   | 2.0% (99) | 3.1%        | 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) <sup>(QOF)</sup> | 88.6%     | 92.6%       | 91.1%           | No statistical variation |
| Exception rate (number of exceptions).   | 1.6% (11) | 2.3%        | 5.9%            | N/A                      |

## Families, children and young people

## Population group rating: Inadequate

| Findings  |
|---|
| <ul style="list-style-type: none"> <li>Immunisation rates met the 90% minimum in two indicators and the 95% World health Organisation target in the other two indicators.</li> <li>The practice offered a range of reversible contraceptive advice and services including intrauterine coils and implants.</li> <li>Emergency contraception was available.</li> </ul> |

| Child Immunisation  | Numerator | Denominator | Practice % | Comparison to WHO target of 95% |
|---|-----------|-------------|------------|---------------------------------|
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 | 190       | 205         | 92.7%      | Met 90% minimum                 |

|   |     |     |       |                          |
|---|-----|-----|-------|--------------------------|
| 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)           | 168 | 184 | 91.3% | 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) | 176 | 184 | 95.7% | 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)  | 176 | 184 | 95.7% | 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: Inadequate

### Findings

- The cervical cancer screening rate was below the 80% target and below 70% uptake.
- The breast cancer screening rate was below national and local averages.
- The screening rate for bowel cancer was below national and local averages.
- NHS Health checks were offered for patients aged 40 to 74.

| 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) (01/04/2017 to 31/03/2018) (Public Health England) | 69.3%    | N/A         | 80% Target      | Below 70% uptake   |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)   | 68.8%    | 73.7%       | 72.1%           | N/A                |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)   | 51.7%    | 58.3%       | 57.3%           | 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   | 85.1%    | 58.7%       | 69.3%           | N/A                |

|  |       |       |       |                          |
|--|-------|-------|-------|--------------------------|
| diagnosis. (01/04/2017 to 31/03/2018) <small>(PHE)</small>   |       |       |       |                          |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) <small>(PHE)</small> | 44.3% | 51.2% | 51.9% | No statistical variation |

**People whose circumstances make them vulnerable**

**Population group rating: Inadequate**

| Findings   |
|--|
| <ul style="list-style-type: none"> <li>• End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.</li> <li>• All patients on the learning disability register were invited for an annual health check and the practice produced a health action plan with them and their carer where appropriate.</li> <li>• The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.</li> </ul> |

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

**Population group rating: Inadequate**

| Findings   |
|--|
| <ul style="list-style-type: none"> <li>• The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia.</li> <li>• QOF achievement for this population group was higher than both the CCG and national averages in all three indicators.</li> <li>• Exception reporting was high in the three mental health indicators.</li> </ul> |

| Mental Health Indicators  | Practice | CCG average | England average | England comparison       |
|---|----------|-------------|-----------------|--------------------------|
| The percentage of patients with schizophrenia, bipolar affective disorder and | 95.6%    | 83.5%       | 89.4%           | No statistical variation |

|   |            |       |       |                                      |
|---|------------|-------|-------|--------------------------------------|
| 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) (QOF)  |            |       |       |                                      |
| Exception rate (number of exceptions).  | 43.1% (69) | 20.8% | 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) (QOF) | 97.5%      | 88.0% | 90.2% | Tending towards variation (positive) |
| Exception rate (number of exceptions).  | 26.3% (42) | 16.7% | 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) (QOF)                             | 98.1%      | 86.1% | 83.6% | Significant Variation (positive)     |
| Exception rate (number of exceptions).  | 17.3% (45) | 10.7% | 6.7%  | N/A                                  |

## Monitoring care and treatment

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

| Indicator                                      | Practice | CCG average | England average |
|--|----------|-------------|-----------------|
| Overall QOF score (out of maximum 559)         | 479.5    | 539.2       | 539.2           |
| Overall QOF score (as a percentage of maximum) | 85.8%    | 96.4%       | 96.4%           |
| Overall QOF exception reporting (all domains)  | 3.8%     | 9.12%       | 10.02%          |

|   | Y/N/Partial |
|---|-------------|
| Clinicians took part in national and local quality improvement initiatives.   | No          |
| The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements. | No (1)      |
| Quality improvement activity was targeted at the areas where there were concerns.   | No          |
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.                                    | No (2)      |

(1) We noted that overall QOF attainment had decreased steadily since 2014/15 when the practice achieved 95.7% or 534.92 of the 559 points available. We asked two of the partners about the decrease and they told us they thought the QOF figures were affected as there was only one chronic disease nurse who has been off long-term sick, although GPs were able to do the reviews as well. They said there had been difficulties in recruiting staff and this had a direct impact on QOF attainment.

(2) Data we received from the clinical commissioning group showed that although Beacon Medical



Practice patient list accounted for 8.8% of the CCG total list, their patients accounted for 17.4% of emergency attendances at A&E from August 2018 to August 2019.

Of those patients who attended accident and emergency departments on five or more occasions in the period, Beacon patients accounted for 21.9% of the CCG total.

The Registered Manager told us that they did not think anyone was monitoring unplanned admissions as he thought one of the clinical practitioners who had the role had left. The same question was asked of another partner who said the practitioner was still working and was still monitoring unplanned admissions. We confirmed that this practitioner was still working at the practice.

The practice could not evidence that they were taking any action to reduce the numbers of patients attending A&E or unplanned admissions.

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

|   |   |
|---|---|
| The practice had completed a two-cycle audit regarding the prescribing of citalopram and escitalopram | The second cycle showed improved standards of prescribing and subsequently patient safety                   |
| The practice had completed a two-cycle audit regarding the prescribing of statins and amlodipine      | Changes to prescribing practice implemented resulted in improved outcomes and decrease in risk to patients. |

## 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. | Partial (1) |
| 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         |
| Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical  | Yes         |

|   |     |
|---|-----|
| supervision and revalidation. They were supported to meet the requirements of professional revalidation.  |     |
| 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:<br>(1) Although nurses who took undertook cervical cancer screening were appropriately trained they did not complete any audits of their sample taking. |     |

### Coordinating care and treatment

#### Staff did not work 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)<br>(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.   | No (1)      |
| 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:<br>(1) Patients discharged from hospital were not followed up on by the practice unless there was a specific request in the hospital discharge note. |             |

### Helping patients to live healthier lives

#### Staff were 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 |

| 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 (01/04/2018 to 31/03/2019) <small>(QOF)</small> | 95.8%     | 95.3%       | 95.0%           | No statistical variation |
| Exception rate (number of exceptions).  | 0.5% (36) | 0.7%        | 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 decide.                | Yes         |
| The practice monitored the process for seeking consent appropriately.  | Yes         |
| Policies for any online services offered were in line with national guidance.  | N/A         |

## Caring

## Rating: Requires improvement

We rated the practice as requires improvement for providing caring services because:

- Feedback from patients on NHS Choices, the CCG listening clinic and GP Patient Survey showed dissatisfaction.

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         |

| Source  | Feedback  |
|---|---|
| Clinical Commissioning Group listening clinic | The CCG held a listening clinic at the practice on 11 September 2019. In total 56 patients took part. The feedback was generally positive in relation to the attitude of staff at the Skegness site. 67% (16/24) of patients who mentioned staff attitude gave positive feedback. 25% (6/24) gave mixed feedback and 8% (2/24) gave negative feedback. At the Chapel St Leonards branch surgery, 75% gave positive feedback and 25% negative feedback with regards to staff attitude. |

### National GP Survey results

| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 22148                    | 279              | 122              | 43.7%                 | 0.55%                    |

| 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) | 80.9%    | 85.5%       | 88.9%           | Tending towards variation (negative) |

| 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 treating them with care and concern (01/01/2019 to 31/03/2019) | 77.1%    | 84.7%       | 87.4%           | Tending towards variation (negative) |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)                              | 90.1%    | 93.5%       | 95.5%           | Tending towards variation (negative) |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)   | 57.0%    | 76.8%       | 82.9%           | Variation (negative)                 |

| Any additional evidence or comments  |
|--|
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice had decreased significantly since 2013 when it was 76.2%. This represented a 19.1% drop in satisfaction. Over the same period, across the CCG, the rate had fallen from 84.2% to 76.8%, a drop of 7.4%. |

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

### Involvement in decisions about care and treatment

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

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

## 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) | 88.7%    | 91.6%       | 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:<br>There was no hearing loop available.   |             |

|   |  |
|---|--|
| Percentage and number of carers identified.                 | 502 which was 2.27% of the patient list. (1)   |
| How the practice supported carers (including young carers). | The practice sign-posted carers to other support services and agencies. Carers information was displayed in patient waiting areas. |
| How the practice supported recently bereaved patients.      | The practice sent a letter to the next of kin offering support.  |

|   |  |
|---|--|
| Explanation of any answers and additional evidence:<br>(1) Two of the GP partners, one of whom was the Registered Manager, told us that there was no carers register and there was no coding of carers in clinical records. The figures above were taken from the clinical system indicating that the two GPs were mistaken or were not aware of the system and process in place 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         |

## Responsive

## Rating: Inadequate

We rated the provider as inadequate for providing responsive services.

- There was patient dissatisfaction regarding access to and the number of clinical appointments available.
- Our own analysis of appointment availability supported the premise that there were insufficient numbers of clinical appointments available.
- The provider had not taken any action to address the shortfall and had reduced the number of GP appointments available.

The areas of concern affected all population groups, so we rated all population groups as inadequate.

## Responding to and meeting people's needs

### Services did not meet patients' needs.

|  | Y/N/Partial |
|--|-------------|
| The practice understood the needs of its local population and had developed services in response to those needs. | No (1)      |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided.    | No          |
| The facilities and premises were appropriate for the services being delivered.                                   | Partial (2) |
| The practice made reasonable adjustments when patients found it hard to access services.                         | No (3)      |

|   |     |
|---|-----|
| There were arrangements in place for people who need translation services.  | Yes |
| The practice complied with the Accessible Information Standard.   | Yes |
| Explanation of any answers and additional evidence:   |     |
| (1) Although the provider was aware of the healthcare needs of its patients, measures had not been taken to ensure that their needs were met through access to enough clinical appointments.  |     |
| (2) The surgery at Chapel St Leonards needed refurbishment and / or replacement. The interior was cramped and difficult to negotiate with wheelchairs or babies' pushchairs. The PPG had helped to identify a site for a new surgery. The partners were aware of the shortcomings at this branch and told us they had been trying for several years to provide alternative premises. CQC had previously raised concerns about the premises with the clinical commissioning group. |     |
| (3) No hearing loop was available   |     |

| Practice Opening Times  |                    |
|---|--------------------|
| Day   | Time               |
| Opening times:  | Skegness           |
| Monday  | 8am to 6.30pm      |
| Tuesday   | 8am to 6.30pm      |
| Wednesday   | 8am to 6.30pm      |
| Thursday  | 8am to 6.30pm      |
| Friday  | 8am to 6.30pm      |
|   |                    |
|   | Chapel St Leonards |
| Monday  | 8am to 5.30pm      |
| Tuesday   | 8am to 5.30pm      |
| Wednesday   | 8am to 5.30pm      |
| Thursday  | 8am to 5.30pm      |
| Friday  | 8am to 5.30pm      |
|   |                    |
|   | Ingoldmells        |
| Monday  | 8am to 5.30pm      |
| Tuesday   | 8am to 5.30pm      |
| Wednesday   | 8am to 5.30pm      |
| Thursday  | 8am to 5.30pm      |
| Friday  | 8am to 5.30pm      |
| GP extended hours appointments:   |                    |
| Were available from 6.30pm to 8pm Monday to Friday and 9am to 1pm or 10am to 2pm Saturday, Sunday and bank holidays at the Ingoldmells branch surgery and delivered by a different healthcare provider. |                    |



| Practice population size | Surveys sent out | Surveys returned | Survey Response rate% | % of practice population |
|--------------------------|------------------|------------------|-----------------------|--------------------------|
| 22148                    | 279              | 122              | 43.7%                 | 0.55%                    |

| 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) | 90.1%    | 93.4%       | 94.5%           | No statistical variation |

## Older people

## Population group rating: Inadequate

### Findings

- The practice had ceased providing ear irrigation, spirometry and ECGs. Patients from Beacon Medical Centre could now access these services at a practice in Old Leake, 13 miles from Skegness.
- Extended hours appointments were available from 6.30pm to 8pm Monday to Friday and 9am to 1pm or 10am to 2pm Saturday, Sunday and bank holidays at the Ingoldmells surgery. This service was provided by another healthcare provider.
- There was on-line booking of appointments available.
- Repeat prescriptions could be ordered on-line.

## People with long-term conditions

## Population group rating: Inadequate

### Findings

- Extended hours appointments were available from 6.30pm to 8pm Monday to Friday and 9am to 1pm or 10am to 2pm Saturday, Sunday and bank holidays at the Ingoldmells branch surgery and provided by a different health care provider surgery.
- There was on-line booking of appointments available.
- Repeat prescriptions could be ordered on-line.

## Families, children and young people

## Population group rating: Inadequate

### Findings

- Appointments were available outside of school hours.
- Extended hours appointments were available from 6.30pm to 8pm Monday to Friday and 9am to 1pm or 10am to 2pm Saturday, Sunday and bank holidays at the Ingoldmells surgery by another healthcare provider.
- There was on-line booking of appointments available.
- Repeat prescriptions could be ordered on-line.

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

**Population group rating: Inadequate**

#### **Findings**

- Extended hours appointments were available from 6.30pm to 8pm Monday to Friday and 9am to 1pm or 10am to 2pm Saturday, Sunday and bank holidays at the Ingoldmells surgery by another healthcare provider.
- There was on-line booking of appointments available.
- Repeat prescriptions could be ordered on-line.

### **People whose circumstances make them vulnerable**

**Population group rating: Inadequate**

#### **Findings**

- There was on-line booking of appointments available.
- Repeat prescriptions could be ordered on-line.
- Extended hours appointments were available from 6.30pm to 8pm Monday to Friday and 9am to 1pm or 10am to 2pm Saturday, Sunday and bank holidays at the Ingoldmells surgery by another healthcare provider.

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

**Population group rating: Inadequate**

#### **Findings**

- Extended hours appointments were available from 6.30pm to 8pm Monday to Friday and 9am to 1pm or 10am to 2pm Saturday, Sunday and bank holidays at the Ingoldmells surgery by another healthcare provider.
- There was on-line booking of appointments available.

- Repeat prescriptions could be ordered on-line.

## Timely access to the service

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

|   | Y/N/Partial |
|---|-------------|
| Patients with urgent needs had their care prioritised.  | No          |
| 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.  | No          |
| <p>Explanation of any answers and additional evidence:</p> <p>We were aware of concerns from various sources that patients were unable to access appointments in a timely manner. We looked at the number of consultations that had been completed by GPs and practitioners over three weeks chosen at random.</p> <p>In the week commencing 12 August 2019 there had been 818 consultations.</p> <p>In the week commencing 23 September 2019 there had been 669 consultations.</p> <p>In the week commencing 11 November 2019 there had been 617 consultations.</p> <p>We noted that on 27 September two of the consultations with a GP were for heavy goods vehicles drivers' medicals which were private work and did not form part of the GMS contract.</p> <p>The provider told us that the number of consultations that could be offered was limited by the difficulty in recruitment, although we also noted that one of the partners had decreased their number of clinical sessions by three per week to enable them to concentrate on management of the practice. Another partner had also reduced their number of clinical sessions.</p> <p>All four of the GP patient survey indicators relating to access were lower than both the CCG and national averages.</p> <p>The listening clinic conducted on 11 September 2019 and which captured the views of 56 patients across all three surgeries showed dissatisfaction with access to services. At Skegness 79% expressed negative views, at Ingoldmells 55% and at Chapel St Leonards 83%.</p> <p>There had been five postings on the NHS Choices website in the 12 months prior to the inspection. All five expressed dissatisfaction with getting an appointment. One related to a child. The respondent had posted that they were told to go to A&amp;E as there were no appointments for the next six days.</p> |             |

## National GP Survey results

| 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) | 25.1%    | N/A         | 68.3%           | Significant Variation (negative)     |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)                             | 42.0%    | 60.8%       | 67.4%           | Variation (negative)                 |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)                    | 37.8%    | 58.7%       | 64.7%           | Variation (negative)                 |
| The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)                     | 58.3%    | 70.0%       | 73.6%           | Tending towards variation (negative) |

### Any additional evidence or comments

The practice could not demonstrate that they had taken any positive action to address the dissatisfaction with either telephone access or appointment times.

## Listening and learning from concerns and complaints

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

| Complaints   |     |
|--|-----|
| Number of complaints received in the last year.                                    | 36  |
| Number of complaints we examined.  | six |
| Number of complaints we examined that were satisfactorily handled in a timely way. | six |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman.   | one |

|   | Y/N/Partial |
|---|-------------|
| Information about how to complain was readily available.  | Yes         |
| There was evidence that complaints were used to drive continuous improvement.   | No          |
| Explanation of any answers and additional evidence:<br>The provider could not furnish any evidence that learning from complaints had been used to drive improvement. We noted that a recurring theme was several complaints concerning one GP. We asked what action had been taken to address this and we were told that it was believed the GP had been spoken to. There was no documented evidence to that effect that we were given access to.<br>We also noted that this GP was mentioned by two patients in the CCG listening clinic held on 11 September 2019 and for which the practice had received the report. |             |

## Well-led

## Rating: Inadequate

We rated the practice as inadequate for providing well-led services because:

- Leaders could not show that they had the capacity and skills to deliver high quality, sustainable care.
- While the practice had a vision, that vision was not supported by a credible strategy.
- The practice culture did not effectively support high quality sustainable care.
- The overall governance arrangements were ineffective.
- The practice did not have clear and effective processes for managing risks, issues and performance.

### Leadership capacity and capability

**Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.**

|  | Y/N/Partial |
|--|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability.  | No          |
| They had identified the actions necessary to address these challenges.   | No          |
| Staff reported that leaders were visible and approachable.   | No          |
| There was a leadership development programme, including a succession plan.   | No          |
| Explanation of any answers and additional evidence:<br>The provider had taken the decision to operate without a practice manager being in place and had done so since the spring of 2019. GP partners had reduced their clinical hours in order to take on administrative responsibilities. This had a consequential effect in reducing the number of clinical |             |

appointments available to patients.

The partners had not taken any significant steps to address the shortage of appointments.

We found the management structure of the practice to be fractured and unclear, with managers unsure of their responsibilities and little or no resilience if any key member of staff was absent from the practice, for example, because of sickness.

Non-clinical practice leaders had little direct practice management experience and although we found them to be enthusiastic and eager to learn, they were currently lacking knowledge in key areas and unable to access certain documents pivotal to the effective running of the practice. Since the inspection we have been informed that a member of staff has taken part in the Practice Manager Academy training provided by the Local Medical Committee.

## Vision and strategy

**The practice had a vision, but it was not 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.  | No          |
| There was a realistic strategy to achieve their priorities.   | No          |
| The vision, values and strategy were developed in collaboration with staff, patients and external partners.   | No          |
| Staff knew and understood the vision, values and strategy and their role in achieving them.   | No          |
| Progress against delivery of the strategy was monitored.  | No          |
| Explanation of any answers and additional evidence:<br>Whilst we were told by the partners that their aim was to provide the very best healthcare there was little evidence to support that they had taken positive action to achieve it. There was no evidence that staff were actively involved in developing or implementing the vision of the practice.<br>Senior leaders did not demonstrate that they had clear oversight of appointment availability or the dissatisfaction of patients in terms of getting an appointment or that they had taken any steps to address it. |             |

## Culture

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

|   | Y/N/Partial |
|---|-------------|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | No (1)      |
| Staff reported that they felt able to raise concerns without fear of retribution.           | No          |

|  |        |
|--|--------|
| 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.  | No (2) |
| When people were affected by things that went wrong they were given an apology and informed of any resulting action.   | No (2) |
| The practice encouraged candour, openness and honesty.   | No (2) |
| The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.  | Yes    |
| The practice had access to a Freedom to Speak Up Guardian.   | Yes    |
| Staff had undertaken equality and diversity training.  | Yes    |
| <p>Explanation of any answers and additional evidence:</p> <p>(1) The provider had been aware that one of the partners was undertaking private work, that would normally be done by the provider as an NHS service and although we were satisfied with the explanation that the other partners had spoken to them about it, there was evidence from third party sources that it was still occurring and nothing positive had been done. The issue had been further highlighted in the CCG patient listening clinic.</p> <p>(2) Patient complaints regarding GPs had not been appropriately dealt with, with numerous complaints relating to one partner. Although the practice management had sought an explanation from this GP, we saw they had not responded so we could not be assured that this demonstrated a culture of openness and honesty.</p> |        |

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

| Source | Feedback  |
|--------|---|
| Staff  | <p>Staff we spoke with had differing views. Some said they enjoyed working at the practice and got on well with the partners whilst others stated that they found particular GPs offhand and dismissive.</p> <p>All staff we spoke with acknowledged that appointment availability was a significant issue.</p> |

#### Governance arrangements

#### The overall governance arrangements were ineffective.

|   | Y/N/Partial |
|---|-------------|
| There were governance structures and systems which were regularly reviewed.   | No (1)      |
| Staff were clear about their roles and responsibilities.  | No (2)      |
| There were appropriate governance arrangements with third parties.  | Yes         |
| <p>Explanation of any answers and additional evidence:</p> <p>(1) The governance structures were ineffective. The system of having a GP partner acting in a practice manager capacity did not provide effective governance.</p> |             |

(2) Nursing staff, receptionists, dispensers and some managerial staff were clear in their roles and what was expected of them. Other managers, whilst performing their roles were in some cases unsure of their responsibilities nor was there any clear process of what they should do in the absence of other staff in managerial positions. The practice had not established effective governance arrangements to compensate for the departure of the previous practice manager.

### Managing risks, issues and performance

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

|   | Y/N/Partial |
|---|-------------|
| There were comprehensive assurance systems which were regularly reviewed and improved.  | No          |
| There were processes to manage performance.   | No (1)      |
| There was a systematic programme of clinical and internal audit.  | Yes         |
| A major incident plan was in place.   | Partial (2) |
| Staff were trained in preparation for major incidents.  | No          |
| When considering service developments or changes, the impact on quality and sustainability was assessed.  | No          |
| <p>Explanation of any answers and additional evidence:</p> <p>(1) The provider did not have an effective system to oversee and manage practice performance as indicated by the poor patient satisfaction and decreasing QOF performance data.</p> <p>(2) The major incident plan had last been reviewed and updated in July 2017. Policies within and pertaining to the plan had not been reviewed or updated since January and July 2014. The documents contained details of staff who no longer worked at the practice.</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.  | No (1)      |
| Performance information was used to hold staff and management to account.   | No (1)      |
| Our inspection indicated that information was accurate, valid, reliable and timely.   | No (2)      |
| There were effective arrangements for identifying, managing and mitigating risks.   | No (3)      |
| Staff whose responsibilities included making statutory notifications understood what this entails.  | Yes         |
| <p>Explanation of any answers and additional evidence:</p> <p>(1) Despite lower than average QOF attainment and substantially lower than average GP patient survey scores, there was no evidence that the practice had acted to use that data to improve performance. Two of the GP partners had reduced the number of clinical sessions they provided.</p> |             |



- (2) We were aware that patient records did not always contain accurate information.  
 (3) The provider had taken no action to manage and mitigate the risk posed by having fewer clinical appointments available.

## Engagement with patients, the public, staff and external partners

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

|   | Y/N/Partial |
|---|-------------|
| Patient views were acted on to improve services and culture.  | No (1)      |
| The practice had an active Patient Participation Group.   | Yes         |
| Staff views were reflected in the planning and delivery of services.  | No          |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.  | Partial (2) |
| Explanation of any answers and additional evidence:<br>(1) There had been five posts on the NHS Choices website in the previous 12 months that all related to poor access to services. The practice had not taken the opportunity to respond to any of the comments.<br><br>(2) There was evidence of working with other stakeholders, but the CCG expressed concerns that the practice did not fully engage at locality level. |             |

Feedback from Patient Participation Group.

| Feedback  |
|---|
| The Chair of the PPG told us that there were 16 active members of the group. They confirmed that there was a lot of patient dissatisfaction around appointment availability. They had not carried out any patient surveys. The minutes of the meetings had not been made publicly available on the practice website since January 2018.<br>The group had made a positive contribution by campaigning for, and getting, a bus stop sited immediately outside the branch surgery in Ingoldmells.<br>They had also been active in sourcing a potential site for a new build surgery in Chapel St Leonards. |

## Continuous improvement and innovation

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

|  | Y/N/Partial |
|--|-------------|
| There was a focus on continuous learning and improvement.      | Partial (1) |
| Learning was shared effectively and used to make improvements. | Partial (2) |
| Explanation of any answers and additional evidence:            |             |

- (1) Although the provider encouraged staff development, there was little focus on service improvement as evidenced from the lack of positive action to address the shortage of clinical appointments and poor access to services.
- (2) Learning from clinical audit was shared at clinical meetings. Serious events were discussed, and learning shared at clinical and staff meetings.

**Notes: CQC GP Insight**

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

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

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

The following language is used for showing variation:

| Variation Bands                      | Z-score threshold |
|--------------------------------------|-------------------|
| Significant variation (positive)     | ≤-3               |
| Variation (positive)                 | >-3 and ≤-2       |
| Tending towards variation (positive) | >-2 and ≤-1.5     |
| No statistical variation             | <1.5 and >-1.5    |
| Tending towards variation (negative) | ≥1.5 and <2       |
| Variation (negative)                 | ≥2 and <3         |
| Significant variation (negative)     | ≥3                |

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

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

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

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

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

**Glossary of terms used in the data.**

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