

# Care Quality Commission

## Inspection Evidence Table

### Horsmans Place Partnership (1-565604154)

Inspection date: 10 May 2022 to 17 May 2022

Date of data download: 05 May 2022

## Overall rating: Inadequate

### Safe

### Rating: Inadequate

We rated the practice as Inadequate for providing safe services because:

- Safeguarding policies had not recently been reviewed and updated.
- The practice's computer system did not alert staff of all family and other household members of children that were on the risk register.
- Evidence that Disclosure and Barring Service (DBS) checks had been seen by the practice was not always available.
- Recruitment checks were not always carried out in accordance with regulations and practice policy.
- Staff vaccination was not always maintained in line with current Public Health England guidance.
- Risks to patients, staff and visitors were not always assessed, monitored or managed effectively.
- There was no record that reception staff had received training in the identification of 'red flag' signs or symptoms of sepsis in patients.
- The arrangements for managing medicines did not always keep patients safe.
- There was no formal clinical supervision or audit of the prescribing/consultations of non-medical prescribers.
- Learning from significant events was not always shared with relevant staff.
- Systems for managing safety alerts were not always effective.

#### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y

Safeguarding	Y/N/Partial
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	N
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.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was a safeguarding adults policy, but it was dated as revised June 2014 with a review date of June 2015. The safeguarding lead was identified in the document and was current (one of the GP partners). The policy advised staff to report concerns to the manager or patient's GP and mentioned referral to the safeguarding lead. The policy was extensive with many contact details, but as the policy had last been reviewed in 2014, the provider could not be assured that these details were current.</p> <p>The safeguarding children policy was dated September 2012. The correct lead was stated on the policy. The deputy was currently on extended leave. The practice had advised us of the name of the current deputy.</p> <p>Safeguarding referral pathways and up to date contact numbers were all clearly visible in clinical rooms.</p> <p>The practice put alerts on the computer records of vulnerable adults and children at risk, but not necessarily the household members of children at risk. Following the inspection, they advised us that they had now done this.</p> <p>We were told that staff would not start work until a Disclosure and Barring Service (DBS) check had been completed. Prior to our site visit the practice sent information which listed staff who had been subject to a DBS check. We found that not all staff employed by the practice, including some clinical staff, were included within the list. During our site visit on 17 May 2022 we reviewed the personnel files of five staff members. We found that there were no DBS records available for three of those staff members. There had been no assessment of the risks associated with the roles of those staff members, nor those omitted from the list of staff who had been subjected to a DBS check, to have contact with patients without having had a DBS check. Subsequently the practice produced a DBS certificate for one staff member, and another produced their own transferable certificate which the practice had not recorded. The practice could not locate a certificate for the third member of staff.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	N
<p>Explanation of any answers and additional evidence:</p> <p>There was a recruitment policy available which was last reviewed on 24 May 2019. This included a requirement to check two references for the successful candidate.</p> <p>During the inspection we reviewed the personnel files of five staff members. Reviews of the files revealed that staff records were inconsistent/variable. For example, we found that no curriculum vitae (CV) or application form was held for two clinical members of staff. There were no references held for four clinical members of staff.</p>	

Prior to our site visit we requested a copy of the staff immunisation policy and information relating to the immunisation status of staff. We were sent logs of staff measles, mumps and rubella (MMR) and Hepatitis B immunisations which were incomplete and did not include records relating to all relevant staff members. We were also sent a staff immunisation policy dated 12 May 2022. The policy reflected current guidance in relation to staff immunisation requirements. At the site visit on 17 May 2022 we reviewed the personnel records of five staff members. Our review of personnel files identified a record of Hepatitis B status for two clinical staff members. There were no other vaccination records available for those staff members. There were variable immunisation records available relating to other staff members. Personnel records we reviewed and the practice's MMR and Hepatitis B log, did not reflect the practice policy in monitoring the immunisation status of staff.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 18/06/2021	Partial
There was a fire procedure.	Y
Date of fire risk assessment: March 2021 Actions from fire risk assessment were identified and completed.	Partial

Several health and safety risk assessments had been carried out by staff. These included a health and safety/general risk assessment completed on 18/06/2021 and due for review on 18/06/2022. There was no action plan (all criteria were met). This included risk assessments for several areas including display screen equipment, electrical hazards, infection control, visitor access, stress, uneven wet, slippery floors, violence and threatening behaviour, work equipment and data protection. Control of substances hazardous to health (COSHH) risk assessments had been reviewed on 01/04/2022.

We did not see a health and safety notice in the building.

There was a Legionella risk assessment, however it was not dated and had been completed by a staff member who had not been specifically trained to do so. The risk assessment identified a requirement to monitor temperatures of the water from outlets once a month. However, only sporadic monitoring had taken place in 2017 and 2019 and no monitoring had been carried out since September 2019. Temperatures outside of the recommended range had been recorded at this time but had not been acted upon.

The risk assessment stated that the findings showed that the likelihood of legionella bacteria being present was low, so no further action was needed. This document had Horsmans Place as the title, but another practice was named above the monitoring section.

No evidence that samples had been sent for analysis for Legionella was found. Therefore the provider could not be assured that the risks associated with Legionella were mitigated.

The practice had a fire risk assessment (dated March 2021), but it had been completed by a staff member who had not been specifically trained to do so. There were no actions required as no risks were identified and no action plan or review date was recorded.

A personal emergency evacuation plan (PEEP), was seen which contained information specific to the practice. (The most recent document seen was date issued 10/03/2021, date to be reviewed 10/03/2022). It stated who was responsible for ensuring patients with disabilities or patients who had mobility difficulties could evacuate the practice safely. Clinicians were responsible for patients in their clinical rooms and reception staff were responsible for patients in the waiting room.

Fire evacuation plans were seen on the walls in administration offices, in the waiting room and in the corridor upstairs. These were last reviewed however, in January 2019, therefore a review of these plans was required.

Fire extinguishers were in date (May 2021). A fire extinguisher maintenance certificate was seen that showed that the fire extinguishers and fire blanket had undergone servicing on 28/05/2021.

Fire drill records were seen. The most recent drill was on 11/05/2022 and showed no actions needed. Records of other fire drills were seen that took place on 16/06/2020 and 13/06/2019.

Fire alarm system testing records were seen. Alarm tests had been carried out eight times in the last 12 months, the most recent being 25/04/2022. There was testing planned for 18/05/2022.

There were three fire marshals named. Two had received fire marshal training, the third had received standard fire training. One of the marshals was currently on extended leave.

A fire detection and fire alarm system inspection and servicing certificate was seen dated 10/03/2022 which showed the system had passed inspection.

An emergency lighting inspection and test certificate was seen dated 25/11/2021.

Since the inspection the practice provided us with email evidence that legionella and fire risk assessments of the practice had been booked to be carried out by specialist providers.

## Infection prevention and control

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

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: February 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Partial
Explanation of any answers and additional evidence: We were initially sent an infection prevention and control (IPC) policy prior to inspection. This had no issue date and stated it was version 1 and had been reviewed in April 2020. The policy lacked sufficient detail to provide guidance to staff and included reference to staff in lead roles who were no longer employed by the practice. A second IPC policy was identified by staff on the internal documents system and was seen at the site visit. There was no date on the policy or version number although the expiry date was 1/6/2022. The policy included an IPC checklist/audit template different to that used to audit the practice's IPC arrangements in Feb 2022. This was a more comprehensive policy and included for	

example, guidance on single use instruments, needlestick injury protocol, use of sharps bins, isolation of patients and notifiable diseases. However, it was unclear which of the two policies staff were expected to follow, as both were accessible on the internal practice system.

Staff had received training in infection prevention and control. The IPC lead had only recently taken on the role and had not yet completed more advanced training. They had however been in contact with the IPC lead at the Clinical Commissioning Group (CCG) to seek advice in this regard.

The IPC audit document was labelled April 2022 but marked as completed February 2022. Areas requiring action identified by the audit included a lack of planned cleaning schedules for window blinds and some domestic waste bins that were not pedal operated. Staff told us they were in the process of addressing those areas.

Clinical waste was managed in line with guidance. However, clinical specimens awaiting collection, were on occasions placed in sealed bags in a basket at the bottom of a fridge overnight that was also used to store vaccines. The vaccines were stored on a different level. This does not follow best practice guidance as there is an infection control risk associated with the storage of clinical specimens in the same fridge as vaccines.

## 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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	N
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.	N
There were enough staff to provide appointments and prevent staff from working excessive hours	Y

Explanation of any answers and additional evidence:

We reviewed the support and training in place to enable non-clinical staff within the practice to identify an unwell or deteriorating patient. We found staff were able to contact medical staff for advice. However, there was no formal training in place for staff and no written guidance available to them which would support them in their assessment and decision making in identifying an unwell or deteriorating patient.

We were sent evidence that two days after our inspection, the practice had provided training on sepsis, stroke and myocardial infarct, as part of a training afternoon. We were also sent a copy of the training slides, certificates that were issued and staff feedback.

The practice had not had a practice manager in post since December 2021 despite advertising. The previous manager had been in post less than a year. There was also a senior member of administration/reception staff on long term leave. Staff were covering some of the administration roles

on a short-term basis until a manager and another staff member were appointed. The GP partners took on the lead roles that a manager would normally carry out, with one GP partner being tasked with the lead administrative role. We were advised that staff were assessed as to their skill set prior to taking on any additional administrative roles. The administrative lead GP was specifically allocated to support staff in this. Staff told us that they had been fully appraised of the situation during several meetings and felt supported. Since the inspection, CQC was informed that a permanent manager had been appointed to start in three months time and an interim manager had been appointed to provide support in the meantime.

## Information to deliver safe care and treatment

### Staff did not always 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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Blood results from hospitals outside the area, could not be accessed directly by the practice. Results of blood tests taken at hospital were not sent to the practice unless specifically requested or included as part of correspondence from the hospital. This meant that where a hospital department had taken blood as part of a shared care monitoring arrangement with the practice, there was no recent result available to the prescriber, or evidence that a recent blood result had been seen by the prescriber when high-risk medicines were being prescribed.</p> <p>DNACPR (do not attempt cardiopulmonary resuscitation) documents were stored on the practice system. Copies were sent to the ambulance service and also to the patient. Three examples of these were seen and were appropriately completed.</p> <p>A DNACPR support pack was available to patients on introduction to the practice. This was produced by a third party organisation and included information on checklists, legal guidance, an example form, example letters to NHS England and letter templates. Documentation was also available in 'easy to read' format.</p> <p>Care plans were stored on the practice system and copies given to patients to retain at home should the ambulance service or other agencies need to see them. They were often completed by the frailty nurse who also carried out a frailty assessment. We saw copies of advanced care plans which had been completed appropriately.</p> <p>There was an effective system to send and monitor two week wait and urgent referrals.</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) (01/01/2021 to 31/12/2021) (NHS Business Service Authority - NHSBSA)	0.68	0.79	0.76	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2021 to 31/12/2021) (NHSBSA)	8.1%	9.8%	9.2%	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 (01/07/2021 to 31/12/2021) (NHSBSA)	6.19	5.75	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	90.2‰	133.4‰	129.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) (NHSBSA)	1.40	0.63	0.62	Tending towards variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	6.1‰	6.8‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y



Medicines management	Y/N/Partial
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.	N
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
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.	Y
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.	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Partial
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
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.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
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.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw that there was a process for the safe handling of requests for repeat medicines including controlled drugs which were monitored and had to be signed for. However, there was a lack of audits of controlled drug prescribing.</p> <p>Prior to our inspection and with the practice's consent, a CQC GP specialist advisor accessed the practice's systems to undertake remote searches of patients' clinical records. These searches were indicative of the number of patients at risk due to a lack of monitoring or diagnosis, although they were not conclusive and further investigation of the patient record was needed to assess risks. We sampled a select number of patient records, where any risks were potentially identified, to assess the risks for those individual patients.</p> <p>We saw that medicine reviews took place, however there was a lack of systems for recall which ensured that patients on repeat medicines were regularly and systematically reviewed. For example our searches found that 56 patients who were prescribed a thyroid hormone replacement treatment had not</p>	

undergone the required monitoring within the last 18 months. We looked at five patients in detail. One, patient had last had a monitoring blood test carried out in August 2016 and was last prescribed the replacement treatment in March 2022. The last medicine review for this patient was in May 2017. This patient had also been prescribed an oral contraceptive pill and had not undergone a required blood pressure check since May 2016.

Our search of patient records showed that the total number of patients prescribed 'four or more items on repeat' was 2078. Of those, the total number of patients prescribed 'four or more items on repeat' who had received no medication review in the last 12 months was 1385.

We were told that the practice would have access to a second clinical pharmacist in the very near future and that they would be carrying out medicines reviews as part of their role.

We found there was a lack of effective process for monitoring of patients' health in relation to the use of medicines, including high risk medicines. For example, we saw that 38 patients had been prescribed a medicine used in the management of, amongst other things, rheumatoid arthritis, of which five patients had not been monitored in line with current guidance. One patient had been identified as receiving shared care with a hospital team. The last recorded blood results were dated 30 September 2021. The medicine was last issued on 24 March 2022. When the patient's records were accessed, two computer system alerts appeared on the screen alerting the prescriber to the fact that the patient was on a high risk medicine and required two- monthly blood tests. Three text reminders had been sent to the patient who had not responded, but prescriptions continued to be issued. There were no records to confirm whether blood tests had been carried out by the hospital and seen by the prescriber before prescribing.

Seven patients were found to be on a high risk medicine that aided management of some mental health conditions that required regular blood monitoring. Five patients had not had the required monitoring and we looked at these patients' records in detail. For example, one patient had no record of a blood test ever having been taken to monitor the level of the medicine in the bloodstream. The medicine was still being prescribed and there was no record of discussion of the patient's management with the mental health team. Two other patients had levels of the medicine recorded in 2021 and were both last prescribed the medicine in May 2022. This is well outside the recommended monitoring parameters. Both were sent recent text reminders.

Our searches of patients' clinical records found that 47 patients were prescribed a medicine used to control blood pressure and heart failure. Of those, 19 patients had not undergone the required monitoring.

There were 1189 patients prescribed different medicines used to control high blood pressure of which 278 had not undergone the required monitoring.

39 patients were prescribed a medicine to thin the blood which required regular monitoring. Our searches of patient records showed that six of those patients had not undergone the required monitoring.

The practice were informed of the search findings on the day that our searches took place. They contacted the clinical commissioning group (CCG) medicines optimisation team the next day to seek support in response to the findings. The practice sent us an action plan on 15 May 2022 which outlined the actions they planned to take. At our on-site inspection on 17 May 2022, we saw that issues identified

**Medicines management****Y/N/Partial**

during the remote searches were being followed up. For example, we saw that where hospital blood test results were not previously available when monitoring patients on high risk medicines, the hospital was being contacted by the practice's in-house pharmacy team and the practice were being sent the required results.

The practice had begun to develop a written process for the recall of patients prescribed high risk drugs.

The practice had a clinical supervision policy which was last reviewed in August 2018. The policy described the roles and responsibilities of various clinical staff in relation to the formal clinical supervision of colleagues. There were two non-medical prescribers working at the practice. One was employed by the PCN. Although both told us that they had access to informal help and advice at all times, we did not find any recorded evidence of formal supervision or audits of their prescribing.

Following our inspection, the provider sent us an action plan which included their intention to ensure non-medical prescribers underwent appropriate supervision and monitoring.

The practice did not keep controlled drugs on the premises.

We reviewed the emergency medicines held within the practice. There was a system for monitoring that emergency medicines and equipment were present and in date. However, there was only one dated signature per bag or box of equipment rather than for each individual piece of equipment or medicine.

We looked at six examples of patient group directives (PGDs). All were valid and complete and signed by all nurses prior to signature by the authorising doctor. The practice did not have any staff giving injections that required patient specific directives (PSDs) at the time of the inspection.

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	N/A
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.	N/A
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	N/A
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	N/A
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	N/A
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	N/A
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	N/A
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	N/A
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	N/A
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	N/A
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	N/A
<p>Explanation of any answers and other comments on dispensary services:</p> <p>The practice does not have a dispensary.</p>	

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

The practice had a system to identify and make improvements when things went wrong, but we saw little recorded evidence of learning being shared as a result.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	No
There was evidence of learning and dissemination of information.	No
Number of events recorded in last 12 months:	5
Number of events that required action:	5
<p>Explanation of any answers and additional evidence:</p> <p>Staff knew that if they needed to raise a significant event to contact the practice manager or a GP and where to access the forms (Intradoc system).</p> <p>We saw a log of four recorded significant events and a separate document which included a fifth significant event. Following our inspection, we were sent a document which showed that three of those events had been discussed with staff at the training meeting which took place two days after our inspection. We were told that the events had previously been discussed with staff but there were no minutes of meetings to confirm that.</p> <p>Staff told us that they would sometimes be told of findings from significant events. However, we found there were no records of formal meetings or documented minutes of staff meetings within the last 12 months, within which reported incidents were discussed. We found there were no arrangements in place to review incidents as a team nor to record or disseminate learning or actions taken. We saw that in two out of four sets of nurses' meeting minutes there was an agenda item of 'accidents/near misses'. However, those minutes did not always reflect incidents which had been recorded in the practice log of significant events. We noted that minutes of the nurse meetings did not always include a date in the body of the document although the file name included a date.</p> <p>Staff knew where the whistleblowing policy was stored and what whistleblowing was, but some were unsure as to which outside agencies they could report concerns to.</p>	

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

Event	Specific action taken
<p>05/05/2022 Incorrect use of e-consult.</p> <p>Mother used her own name when constructing an e-consult for her daughter's problems—thus appointment was given in mother's name and documentation for the consultation was added in the mother's name. Only when blood tests were ordered did it become</p>	<p>Advise patient not to use their name on e-consult for other members of the family.</p> <p>Lessons learned</p> <p>19/05/2022</p> <p>Practice discussion regarding the significant event—highlighted to the staff members present always to advise patients to use e-consult under their own names and not their children avoid confusion.</p>

apparent that these were in the mother's name.	Clinicians to be aware of the fact that e-consults are occasionally used for other relatives and children.
13/12/2021 Aggressive patient Aggressive patient attended surgery– required a practice manager to attend– very distressing moment for the staff.	Lessons learned 19/05/2022 Long discussion with staff regarding methods of dealing with aggressive and confrontational patients. Discussed ways of diffusing confrontation–all the staff gave their experiences of aggressive patients--good discussion highlighting their experiences and ways of preventing and de-escalating confrontation.
23/09/2021 Suspected gas leak	Engineers were called, there wasn't a leak, but a bag of rotting food was found. We were told that staff were reminded about storage of food, but there was no record of this advice being disseminated to staff.
26/08/2021 System failure EMIS failure in Kent which lead to a complete loss of being able to take calls from patients and make appointments. The system came back online at approximately 11:00 am.	Lessons learned 19/05/2022 Practice discussed the incident whereby the EMIS computer system went down completely for most of the morning. Adjustments a) always print out the surgery lists for the following day. (Staff had told us that this was introduced at the time of the incident). b) doctors to hand write consultations and later entered into the computer. c) handwritten prescriptions to be photocopied and later entered into the computer notes.
23/06/2021 Needlestick injury to member of staff.	No record of discussion or learning seen.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts	Partial
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Although there was a system for the management of safety alerts, it was not always effective.</p> <p>For example, a Medicines and Healthcare products Regulatory Agency (MHRA) alert from December 2014 advised that one medicine to reduce blood clotting and another used to reduce stomach acidity should not be prescribed together. Searches of the practice's clinical records system showed that five patients were found to be on this combination of medicines, despite having had recent medicines reviews.</p> <p>A search on another MHRA alert from 2014 related to two medicines prescribed to help manage depression. The guidance stated that patients over 65 should not be taking doses over 20 mg a day for</p>	

one of the medicines and 10 mg a day for the other. Searches showed that four patients over 65 had been prescribed doses higher than recommended.

The practice sent us an action plan on 15 May 2022 which outlined the actions they planned to take in response to these findings and to ensure appropriate actions were taken in response to other previous MHRA/CAS medicines safety alerts. CAS is the Central Alerting System.

The practice informed us of a revised process introduced to process any new alerts and to re-run searches on older alerts on a regular basis. They sent us copies of searches that they had since carried out on nine MHRA alerts.

## Effective

## Rating: Requires improvement

We rated the practice as requires improvement for effective because:

- Patients' needs were assessed, but care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- Patients with long-term conditions were not always receiving relevant reviews that included all elements necessary in line with current best practice guidance. Patient reviews were not always followed up in a timely manner where necessary.
- The practice carried out quality improvement activity, but there was not always evidence that they had implemented and followed up on the recommended changes.
- Staff worked together and with other organisations to deliver care and treatment but this was not always effective.

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

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	No
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence:	



Clinicians had access to current national guidance including guidance issued by the National Institute for health and Care Excellence (NICE) and local guidelines and treatment via software on their desktop computers in consultation rooms. We were told that these would be used when considering the criteria for rapid access cancer referrals and other pathways involving for example, cardiology and radiology referrals.

We saw dated, redacted records (but containing patient identifiers) of multi-disciplinary team (MDT) meetings where individual patients were discussed and action plans instigated, but there was no list of attendees in the meeting minutes.

We were told that the practice was a training practice and followed and taught the Royal College of General Practitioners consultation model. We saw that the GP registrars received regular formal clinical supervision.

Patients were advised what action to take should their condition change and clinicians were able to make follow up appointments at the time of consultation if appropriate.

If a clinician went on leave, there was a 'buddy' system in place to ensure, where required, a patient was followed up in a timely way. The buddy system also applied to reviewing and managing letters and test results during absences. Tasks sent by administrative staff to clinicians were checked to ensure that they had been completed. The buddy system also applied to this as well.

We were told that any actions recommended by an extended hours 'hub' GP were actioned within 24 hours.

Non-medical clinicians and administrative staff could always contact medical staff quickly via the internal messaging service or by knocking on a door (there was an open door policy), where necessary. All staff that we talked to found this to be the case.

We saw that trained staff carried out long-term condition reviews. Searches were run and invitations and reminders were sent to patients monthly by a designated administrator. Registers were retained for patients who had been diagnosed with conditions such as asthma, diabetes and chronic obstructive pulmonary disease (COPD).

However, we found instances where diagnoses had been missed or not acted upon. For example, when we ran searches on the practice system on 10 May 2022, we identified 21 patients as having a missed potential diagnosis of diabetes. We looked in detail at five of these patients. One patient had three blood tests above the level for diagnosing diabetes on three occasions in a three year period, which indicated that the patient was diabetic. The patient had not been coded as diabetic despite a system alert flagging this on the clinical system. There was no record of the patient having been informed of the diagnosis, being referred for required eye screening or undergoing regular review of their condition. The patient was not on the Quality Outcome Framework (QOF) register.

Another patient had been identified as diabetic, was on an appropriate medicine, had undergone review and had been referred for eye screening. However, they were not coded as diabetic on the system or on the QOF register.

A third patient who had blood test results suggesting that they were pre-diabetic had not been coded as such on the system and therefore there was a potential for other clinicians to be unaware of this, or the patient not to be appropriately followed up.

We looked at the total number of patients with a particular eye condition related to diabetes and found 48 patients who had the condition. We looked at five patient records in detail and found that one had had an acute event in their eye. Following that, they had a review at the practice. A subsequent review at the hospital found that the patient did not have any blood testing sticks (used regularly by patients with a diagnosis of diabetes to monitor blood sugar levels) despite having been recently seen for a review at the practice.

Our searches showed that 56 patients on a thyroid hormone replacement medicine had not undergone the appropriate monitoring in the previous 18 months.

The practice sent us an action plan on 15 May 2022 which outlined the actions they planned to take in response to these findings and to ensure appropriate actions were taken in future to identify and monitor patients who are or may be diabetic.

## Effective care for the practice population

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. They had a frailty nurse who contacted patients identified with frailty who received a full assessment of their physical, mental and social needs. Their care was reviewed, and care plans implemented in conjunction with the multi-disciplinary team (MDT) at monthly MDT meetings.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check and where appropriate referral to a social prescriber and care co-ordinator.
- 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.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services. The practice had access to an on-site mental health professional.

## Management of people with long term conditions

### Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- A dedicated member of staff sent out recalls for patients due a review of their long-term condition each month. These included texts, emails and letters.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice demonstrated how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. However, this was not always effective.

There were some patients whose condition had not been recognised, coded, recorded and appropriately managed. Others had been identified but were not all receiving the appropriate monitoring or follow up. For example, we looked at five patients with asthma who had been prescribed two or more courses of rescue steroids in the last 12 months. Two of those patients had not had an asthma review in the last year and were not followed up within a week of an acute exacerbation as guidelines recommend. One patient had not been issued with a steroid card.

- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring. Patients with suspected hypertension were also loaned blood pressure meters to facilitate home monitoring.
- Patients with specific cardiac abnormalities were offered three-day ECG monitoring.
- We were told that MDT meetings were attended by social services, community services, representatives from the local hospice and a social prescriber.
- A dietician, physiotherapist and mental health professional were available at the practice.

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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	92	104	88.5%	Below 90% minimum

The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	90	108	83.3%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	90	108	83.3%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	88	108	81.5%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	92	103	89.3%	Below 90% minimum

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

### Any additional evidence or comments

The practice were aware that they were not attaining the 90% minimum target for childhood immunisations.

We were told that a member of administration staff sent tasks to nurses to contact patients who hadn't attended. Letters or text reminders were sent to patients by nurses or the healthcare assistant. We were told that if a child on the risk register failed to attend an immunisation appointment, then health visitors and social services would be informed.

- The practice had a nominated member of staff for young people who acted as an initial point of contact if required.
- Urgent appointments were available on the day for children including appointments outside school hours.
- The GPs held personal lists and where possible family members were all registered with the same GP.
- The practice had access to and referred families to social prescriber's and care coordinators where appropriate.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	64.5%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	28.6%	63.3%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	60.6%	68.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	58.3%	56.3%	55.4%	No statistical variation

#### Any additional evidence or comments

The practice were aware that the uptake for cervical cancer screening was below the 80% target. We saw minutes of nurses meetings where this was discussed and staff were encouraged to promote the uptake where possible. We were told Saturday morning cervical screening clinics were due to start in the near future.

The practice had carried out a quality assurance project to look at reasons for the low uptake of breast cancer screening. Several reasons were given by patients, but there was no documentation to demonstrate that the practice had considered or acted upon the findings.

## Monitoring care and treatment

**The practice carried out quality improvement activity, but there was not always evidence that they had implemented and followed up on the recommended changes.**

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

<p>The practice provided four documents to demonstrate quality improvement:</p> <p>An audit called 'Vitamin D replacement therapy' dated 2020 looked at a cohort of patients who had had blood tests to assess whether or not they had a vitamin D deficiency in 2019. It looked at how many patients in the cohort had a vitamin D insufficiency or deficiency and whether they were provided with appropriate treatment to adequately treat the condition. This was a single cycle audit with various recommendations including a recommendation for a second cycle, but there was no evidence that a second cycle audit had been undertaken.</p> <p>A quality improvement project dated 2021 was carried out to specifically look at the reasons why breast cancer screening uptake was so low in patients registered at Horsmans Place Surgery (28.6% see table above). Various reasons were ascertained including: no reason, too busy, COVID concerns and the location where the screening took place. Various recommendations were made as to how the practice may have attempted to improve uptake. There were no meeting records to evidence whether any of the suggestions had been implemented.</p> <p>We saw a two cycle audit into the monitoring of direct acting oral anti-coagulants (DOACS) which was initiated by the local clinical commissioning group (CCG). The first cycle was run in September 2021 and the second in March 2022. The results of the second cycle showed an improvement in monitoring over the first.</p> <p>The fourth audit was dated 2021 and looked at oral anti-coagulation (blood thinning) and whether patients had been transferred from a blood thinning medicine that was previously the standard, to one of the newer DOACs where appropriate, in line with National Institute for health and Care Excellence (NICE) guidance. There was no evidence that the recommended one-year follow-up had yet been carried out.</p>
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### Any additional evidence or comments

The practice were involved in the national COVID vaccine initiative.

The practice had meetings with their Primary Care Network (PCN) partners to look at the local demographic and local needs and recruitment requirements, partly using QOF results as a source of data, at a PCN level (A PCN is a group of local practices that work together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas). They had access to a clinical pharmacist (a second to start very soon), a pharmacy technician, an on-site physiotherapist and a mental health professional. They could also refer to a social prescriber, and a care co-ordinator was accessible through the PCN.

The practice reviewed unplanned admissions and readmissions where appropriate during MDT meetings.

## Effective staffing

**The practice were not always 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.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff had annual reviews and where appropriate could request additional training. One member of reception staff had trained as a phlebotomist and was undergoing training to be a healthcare assistant (HCA). We saw examples in meeting minutes where requests for additional training were discussed.</p> <p>The nursing team had regular meetings and a lead GP was allocated to them who had attended all of the meetings documented.</p> <p>There were two non-medical prescribers working at the practice. One was employed by the PCN. Although both told us that they had access to informal help and advice at all times, there was not any recorded evidence of formal supervision or audits of their prescribing.</p> <p>Following our inspection, the provider sent us an action plan which included their intention to ensure non-medical prescribers underwent appropriate supervision and monitoring.</p> <p>There was a suite of online training available to all staff that covered a large variety of subjects. Staff were sent reminders when training was due and were seen to be up to date in mandatory training.</p> <p>All staff were issued with a staff handbook on starting at the practice which was also available on the internal practice system. This contained, amongst other information a description of the management of staff performance.</p>	

## Coordinating care and treatment

**Staff worked together and with other organisations to deliver care and treatment which was not always effective.**

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Partial



<p>Patients received consistent, coordinated, person-centred care when they moved between services.</p>	<p>Y</p>
<p>There was an effective system of referral for two week wait, urgent and routine referrals, which were monitored. Patients with care plans had copies at home, as well as being retained on the practice records and there was communication with the local ambulance service where appropriate. We did not find any backlog of documents or test results to be actioned when we inspected.</p> <p>Regular multi-disciplinary team meetings were held and the practice had access to a care co-ordinator who was employed by the PCN.</p> <p>There was however, an issue with the practice being unable to directly access any blood results initiated by hospitals outside of the immediate area. This contributed to a breakdown of the monitoring of some patients who were the subject of a shared care agreement between the practice and secondary care.</p>	

## 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.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Patients could be referred to an on-site physiotherapist, dietician, a social prescriber and a care co-ordinator. One staff member was also the contact for carers and was pro-active in assisting carers once identified.</p>	

## 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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Any patient undergoing minor surgery signed a written consent which was scanned into the records, Clinical staff demonstrated an understanding of Gillick competence and the Frazer guidelines</p> <p>We saw examples of DNACPR decisions, that decisions were made in line with relevant legislation and were appropriate. A copy was on the practice system, the patient had a copy and a further copy was sent to the local ambulance service.</p>	

# Caring

## Rating: Good

### Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: We interviewed several members of clinical and non-clinical staff and all exhibited a caring and non-judgemental attitude towards patient care. Observation of telephone and face to face interactions between staff and patients during our on-site inspection confirmed this impression. One example was that staff responsible for registering patients would take patients who may have problems understanding registration forms and other documentation (possibly because English was not their first language) into a side room where they could go through the form with them in private, without the patient feeling embarrassed. Patients who were of no fixed abode were allowed to use the practice address as their contact details.	

Patient feedback	
Source	Feedback
CQC patient feedback cards from	We looked at 10 CQC feedback cards that had been filled in by patients. All 10 returns were positive about the care that they received at the practice, although one patient did feel that phone access could be improved. Patients used words and phrases such as very lovely, very good, helpful and polite, excellent service and very accommodating to me, when describing their experiences.

## National GP Patient Survey results

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 (01/01/2021 to 31/03/2021)	80.3%	88.2%	89.4%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021)	71.6%	87.3%	88.4%	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 (01/01/2021 to 31/03/2021)	96.9%	95.4%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	64.9%	80.3%	83.0%	Variation (negative)

### Any additional evidence or comments

The practice told us that they were aware of the GP national survey results and had identified several issues which may have contributed to the feedback.

- The feedback took place during the pandemic and they had been unable to recruit a salaried GP or locum.
- They had just recruited new administration and reception staff.
- Telephone triage of patients during the pandemic and the necessary increase in telephone consultations had reduced face to face consultations.
- A practice nurse who patients knew well, had retired.
- Increased numbers of patients were calling the surgery, due to COVID, wanting information.
- The local hospital had stopped carrying out blood tests and patients were reluctant to travel for blood tests.

We were told the practice had made some changes and were in the process of making further changes.

- They were shortly moving to use a cloud-based telephone system which it was hoped would help improve access.
- They had now taken on a long-term GP locum which had increased available appointments.

- E consultation and video consultations were available.
- They had increased the number of face to face consultations
- The health care assistant (HCA) had been trained to extend their role and a receptionist had trained to become an HCA and phlebotomist.

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

Any additional evidence
<p>The practice have Friends and Family test forms on their web page that are prominent and easy to complete. They had not however carried out a feedback exercise in the last year.</p> <p>The practice told us that they used to have a suggestion box in the waiting room, but this was withdrawn during COVID. They have said that they will be restarting this.</p> <p>The practice told us that they were installing a cloud based telephone system in response to patient feedback.</p>

## 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.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>One staff member was dedicated to identifying and supporting carers. They demonstrated an understanding of issues faced by carers. Prior to the pandemic they visited carers' meetings around the area and talked to and advised carers. Patients that were identified as carers were, with their permission, put in touch with a local carers' organisation who contacted them and sent them a carers' handbook.</p> <p>Easy read and pictorial materials were available.</p> <p>There was a room available should any patients wish to discuss issues with staff in private.</p>	

Source	Feedback
Patient comment cards	We received 10 comment cards containing feedback on their care. All 10 were very positive about the quality of the care they received.

## National GP Patient 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 (01/01/2021 to 31/03/2021)	93.6%	93.1%	92.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence:	
There was information about various conditions and support groups in the waiting room.	
Information leaflets could be made available in other languages if requested. There is a translation service available via the practice website and a translation service was available through the practice.	
The website contained links to support services and charities.	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 62 registered carers on the patients register. This is 0.6% of the registered patients.
How the practice supported carers (including young carers).	The practice identified carers and with their permission referred them to a local carers support organisation who contacted them directly within five days. Carers were also sent a support pack. One staff member was dedicated to identifying and supporting carers.
How the practice supported recently bereaved patients.	The whole practice team was made aware of bereavements via the internal messaging service. A condolence card was sent to the bereaved relatives within two days. The GPs phoned relatives to offer support. An appointment was also offered two to three months later. Referral for bereavement counselling was available through the palliative care team.

## Privacy and dignity

### The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence:	
There was a room available if patients wished to speak to staff in confidence. Patients could only go into the waiting room if they had a pre-booked appointment. Patients without an appointment had to stand behind a barrier and knock on an opaque closed window and wait to be answered when the slatted window was opened by a receptionist. We were told that this was because reception staff were	

also answering phones and it helped ensure the privacy of the conversation. There were clear screens in the waiting room between staff and patients.



## Responsive

## Rating: Requires improvement

We rated the practice as Requires Improvement for providing responsive services because:

- There was minimal evidence of learning from complaints being shared with relevant staff.
- Patients experienced difficulty accessing the practice by the telephone and this was a major concern for patients.
- GP patient survey results show that 37.9% of patients were satisfied with the appointment times at the practice. This is lower than the the local and national averages.

### 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.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	
<p>The practice used an online consultation messaging service which allowed patients to access services and advice via the practice website. The GPs ran personal lists so that patients would generally see their own GP. The practice offered book on the day emergency appointments and telephone consultations. Pre-bookable appointments were available from 8 am. There was a self check in service to reduce queueing at the reception desk.</p> <p>Online access to appointments was available as well as repeat prescriptions and access to summarised medical records.</p> <p>There was a pharmacy on the practice site, but this was not run by Horsmans Place Partnership and therefore was not part of this inspection.</p> <p>Access could be arranged to translation services including those for patients with a hearing impairment. Telephone interpretation services allowed patients to be seen for a routine appointment with minimal delay.</p> <p>Patients with dementia were offered longer appointments.</p> <p>Extended hours access was provided by the Primary Care Network (PCN) through a local hub site.</p>	

#### Practice Opening Times

Day	Time
Opening times:	

Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm

Appointments available:

Monday	8am – 11.30am and 2pm – 6.20pm
Tuesday	8am – 11.30am and 2pm – 6.20pm
Wednesday	8am – 11.30am and 2pm – 6.20pm
Thursday	8am – 11.30am and 2pm – 6.20pm
Friday	8am – 11.30am and 2pm – 6.20pm

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

- Patients had a named GP who supported them in whatever setting they lived. The GPs ran personal lists so that patients would generally see their own GP.
- The practice was responsive to the needs of older patients and offered home visits via a paramedic visiting service and urgent appointments for those with enhanced needs and complex medical issues.
- There was a medicines delivery service for housebound patients.
- There was a consent system that allowed nominated individuals to pick up prescriptions or letters or phone in on a patient's behalf.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues. Monthly multi-disciplinary team (MDT) meetings were held.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice opened at 8am each day and offered pre-bookable GP appointments from that time.
- The practice held a register of patients living in vulnerable circumstances including homeless people 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.
- The practice had tried to obtain permission to put a lift into the building, but this had been refused. Patients with a disability that prevented them from managing stairs, were seen in a downstairs consulting room.
- The practice had a wheelchair ramp and disabled toilet.
- There was a room available where parents could feed babies in private.
- There was a learning disability register and patients on the register were linked in with social services. They received an annual review and where appropriate were referred to the social prescriber and care coordinator. Patients with learning difficulties were given longer appointments of up to 30 minutes.
- There was a second, afternoon collection of blood samples. The practice had trained a second phlebotomist and would be offering more appointments. At the time of the inspection patients could have blood tests done on the day at the local hospital or in about a week at the practice. The next bookable nurses appointment was the following week.

## Access to the service

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

*The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.*

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Partial
There were systems in place to support patients who face communication barriers to access treatment	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us that they had several ways that patients may obtain care, treatment and advice. We saw that they provided an online consultation messaging service which allowed patients to send questions, ask for advice and would receive a reply via the system. Patients could pre-book some appointments up to four weeks in advance and directly online. GPs could pre-book follow up appointments for patients. Patients could also access appointments by going directly to the practice or by using the telephone. The practice also told us that they offered video consultations and a text service.</p> <p>The practice were aware that patients were experiencing difficulty accessing the practice by the telephone and this was a major concern for patients.</p> <p>The practice told us that in response to patient concerns they had initiated changes and were installing a new cloud-based telephone system two to three weeks after the inspection and that this system would have up to 100 telephone lines. They were also advertising for an additional member of reception staff.</p> <p>We did note that on the day of the inspection only two members of staff were answering calls and also dealing with the reception desk at the same time. There was one other member of reception staff behind reception who was answering emails, seated away from the reception desk. This presented challenges to the staff answering calls who needed to focus attention on patients on the telephone, as well as the patients who arrived at reception.</p>	

When patients arrived in the lobby prior to entering the waiting area, they could check-in using an automated system if they had an appointment. Only patients who had a booked appointment could go straight into the waiting room. There was a closed, slatted, opaque window in the lobby which was to provide privacy whilst reception staff were receiving phone calls. There was also a tape barrier in front of the window so that patients could not get too close and overhear any conversations. To get the attention of the receptionist, patients would knock on the window which would then be opened to allow a conversation to take place.

The practice had one care home that it looked after, to which they provided a weekly ward round. The practice also had access to a paramedic home visiting team run by a third party organisation. The paramedic team would contact the GP to update them and could access the practice systems to update records electronically.

The front doors to the practice were not automatic, so not immediately accessible to wheelchair users.

The practice had adjusted how it delivered services to meet the needs of patients during the COVID-19 pandemic.

We were told that all vulnerable patients were identified by the practice through age (over the age of 70), organ transplants, active cancer treatments, immunotherapy, chronic diseases (particularly cardiac failure / respiratory) and congenital disorders such as Sickle Cell Disease.

The practice told us that practical actions and advice included:

- They confirmed an understanding regarding shielding and hygiene including regular hand washing in accordance with national guidelines.
- Advised patients of the importance of routine immunisation such as seasonal flu, pneumococcus, and shingles.
- COVID vaccinations were administered at home where required, by a dedicated team from the local General Practice Federation.
- Advised patients on accessing emergency medical care which was delivered via telephone/video or a paramedic home visiting team ran by a local provider. Paramedics would communicate with the GPs to discuss any issues or concerns.
- Social care needs were assessed and if necessary a referral was made to the social prescribing partners.
- They confirmed provision of sufficient medications and they prescribed these electronically if possible.
- The mental health needs of patients were considered holistically as they may suffer significant stress, anxiety and related psychological difficulties through isolation.
- They confirmed the next of kin and utilised close friends/family and NHS volunteers to deliver medications and other supportive care.
- There were regular MDT /GP led ward rounds of the local care home.
- Reviews of patients with learning disabilities were undertaken and referred to the social prescriber and care coordinator for input where appropriate
- The secure video calls system was used to speak to paramedics and action all Hub GP requests.

The practice told us that during COVID, the whole staff team agreed that when dealing with patients they would be supportive in times of stress and always professional and compassionate.

They also implemented all guidelines in respect of infection prevention and control.

Staff were split into two teams who worked on-site in the practice on alternate weeks, so that should members of one team contract COVID, the other could still continue to run the service. They were provided with personal protective equipment and lateral flow tests. All staff members that we spoke to felt that the COVID arrangements worked well and kept them safe.

## National GP Patient 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 (01/01/2021 to 31/03/2021)	32.0%	N/A	67.6%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	50.9%	66.7%	70.6%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	37.9%	63.1%	67.0%	Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	72.4%	80.7%	81.7%	No statistical variation

### Any additional evidence or comments

The practice told us that they were aware of patient feedback with regard to access and had made some changes since the National GP Patient Survey was carried out.

- They were shortly moving to use a cloud based telephone system (in two to three weeks after the inspection) to help improve access.
- They had employed a long-term GP locum which had increased available appointments.
- Econsult, which allowed messages to be sent and replied to, and video consultations were available.
- They told us that they had increased the number of face to face consultations and if a patient specifically wanted one, they would be offered one.
- The health care assistant (HCA) had been trained to extend their role and a receptionist had trained to become an HCA and phlebotomist.

Source	Feedback
For example, NHS Choices	<p>The Horsmans Place Surgery NHS services page had one review: This was a one star review left on 9 May 2022 and detailing multiple failures in accessing the service. No reply yet from Horsmans Place.</p> <p>The practice told us that in the past a patient had been constantly posting negative reviews online. They said that they invited them in to discuss their concerns and that this resolved the issue.</p>

Complaints made to CQC during the previous 12 months	We received seven complaints about the practice in the last 12 months. Six complaints involved access issues with three describing a 17 day to six week wait for a pre-booked appointment. Other patients described waiting for a call back from a GP but not receiving one. The practice had replied that the GP had phoned, but not received an answer. Two patients mentioned long waits for the telephone to be answered.
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## Listening and learning from concerns and complaints

**Complaints were listened and responded to but there was no evidence that they were used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	14
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The complaints log showed that 14 complaints had been received in the last 12 months. We looked at four complaints. Three were clinical issues replied to by GPs and one administrative issue replied to by a previous practice manager. The clinical complaints were all replied to thoroughly, empathetically and where appropriate, patients were offered an apology and clear explanation of the actions taken. One of these had been delayed by a few weeks which was acknowledged by the respondent and an apology made. This was because the clinician had not been made aware of the complaint. The administrative complaint was responded to adequately.</p> <p>The practice's complaints policy noted that an acknowledgement should be sent to the complainant within three days. We were told that this would have been by email but the practice were unable to locate any records of those acknowledgements. We were told that the incidents surrounding a complaint would be discussed and learnt from, but there were no documented meeting minutes to confirm this had happened.</p> <p>We saw that in a practice meeting on 02/08/2021 there was a discussion about a complaint relating to a patient who was unhappy with the treatment received during an ultrasound scan. The minutes said that the practice manager would acknowledge the complaint. There were no other complaints discussed at the practice administration or nurse meetings that we saw from the last 12 months.</p> <p>Of the four complaints that we examined, no specific learning points were identified.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Relatives questioned mothers care for urinary tract infections. They had to attend accident and emergency to obtain antibiotics as they said that these had not been given by the GP.	The respondent was apologetic about the delay in replying. They responded that the patient was already on that particular antibiotic and there were concerns that they were developing resistance to it, so had recommended a urine test. The response appeared to be appropriate, detailed and polite although there were no specific learning points identified.

<p>A complaint was made that during a video consultation the GP gave a vague diagnosis and was unprofessional.</p>	<p>The patient's partner had been present at the consultation and had questioned the treatment and prescription. The respondent was polite and proportionate and offered to refer the patient further. There were no specific learning points identified.</p>
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## Well-led

## Rating: Inadequate

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

- There was compassionate leadership at all levels. However, leaders were not aware of all required improvements to ensure the quality, safety and performance of the service.
- Improvements were required to the processes and systems that supported good governance and management.
- The practice's processes for managing risks, issues and performance were not always effective.
- Processes to manage current and future performance were not sufficiently effective. Improvements to care and treatment were required for some types of patient reviews as well as subsequent follow-up activities.
- The policies and protocols for managing medicines did not always keep patients safe.
- Clinical audit activity did not always demonstrate quality improvement.

### Leadership capacity and capability

**There was compassionate, inclusive but not always effective leadership at all levels, but 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.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<p>The practice had not had a practice manager since December 2021 despite advertising. The previous manager had been in post less than a year. There was also a senior member of administration/reception staff on long term leave. Staff were covering some of the administration roles on a short term basis until a manager and other staff members were appointed. The GP partners took on the lead roles that a manager would normally carry out, with one GP partner being tasked with the lead administrative role. We were advised that staff were assessed as to their skill set prior to taking on any additional administrative roles. The administrative lead GP was specifically allocated to support staff in this. Staff told us that they had been fully appraised of the situation during several meetings and felt supported.</p> <p>We were told that a previous practice manager was helping the practice with some remote administration on an occasional basis.</p> <p>Following our inspection, CQC was informed that a permanent manager had been appointed and an interim manager had been appointed to provide support and would start work shortly in the meantime.</p> <p>We were told that if administration staff were required to work more hours to cover absence they received time off in lieu.</p> <p>One of the GP partners was a GP trainer and the practice was a teaching practice involved in the training of GP registrars. The practice were currently training two GP registrars.</p> <p>We found that there was a lack of awareness by leaders that improvements to quality, safety and</p>	

performance were required in relation to the following:

- Safeguarding, in particular DBS checks
- Staff vaccination
- Risk management.
- Medicines management.
- Safety alerts management.
- Reviews and coding of patients with long-term conditions.
- Non medical clinical staff supervision.

The leaders had developed alongside PCN colleagues, a strategy for improving healthcare in the area. It was because of this that the PCN had identified needs and employed clinical pharmacists, a physiotherapist, mental health professional, care co-ordinator and social prescriber.

Staff told us that the GP partners were approachable and were all very positive about the accessibility of the GPs. There was an open door policy and they felt listened to.

### Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Partial

Explanation of any answers and additional evidence:

The provider had a statement of purpose which reflected the vision of the practice. Staff had been involved in the current strategy due to the lack of a manager and senior member of administrative staff.

## Culture

The practice had a culture to drive high quality sustainable care but this was not always achieved.

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.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	N
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Staff worked well together to support one another, especially as they had been without a practice manager for a few months and a member of staff was on long term leave. All staff talked of the supportive nature of the clinicians and the open door policy within the practice. Staff had taken on additional roles and it was noted that staff members remained behind after their working day was complete to support colleagues during the on-site inspection.</p> <p>However, there were significant areas with respect to governance that needed to be addressed.</p> <p>The practice did not currently have a freedom to speak up guardian.</p>	

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

Source	Feedback
CQC staff feedback questionnaires	We received five staff feedback forms all of which were very positive about the working environment and helpful and approachable attitude of all staff members and GPs. GPs were felt to be proactive in supporting staff and giving guidance. It was felt that they understood the pressure that reception staff were under. Several staff members felt that there was a high standard of caring exhibited by the whole team and that the GDPR and confidentiality systems including patient authority forms were very good. They felt that patients would benefit from automatic front doors and a lift. Staff said that if they wanted appropriate additional training it would normally be agreed. Staff safety was also a priority of the partners. We were told that the practice held three monthly meetings/training afternoons. They included team building exercises. There was a Christmas party each year.

## Governance arrangements

### The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There were policies available on the practice intranet, but many had not been updated for several years. For example, version one of the child safeguarding policy was dated September 2012. The safeguarding lead was correctly identified, but the deputy was currently on extended leave and the policy had not been updated. The adult safeguarding policy had been revised in June 2014 with a review due date of June 2015. There were many contact details in the policy, but it needed to be reviewed to ensure that it was current and tallied with those on the walls in the various rooms in the practice.</p> <p>There was a looked after children-GP practice checklist, but this had last been revised in 24 May 2013.</p> <p>We were initially sent an infection prevention and control (IPC) policy prior to inspection. This had no issue date and stated it was version 1 and had been reviewed in April 2020. The policy lacked sufficient detail to provide guidance to staff and included reference to staff in lead roles who were no longer employed by the practice.</p> <p>A second, more comprehensive IPC policy was identified by staff on the internal documents system and was seen at the site visit. There was no date on the policy or version number although the expiry date was 1/6/2022. It was unclear which of the two policies staff were expected to follow, as both were accessible on the internal practice system.</p> <p>We were sent an incident reporting policy and procedure which was last reviewed in May 2017 and had not been updated since. The policy stated that the practice manager led on this, but did not state who led whilst there was no practice manager in place.</p>	

## 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.	N
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider was unable to demonstrate their processes and systems were effective in the management of risks from:</p> <ul style="list-style-type: none"> <li>• The practice's computer system not alerting staff of all family and other household members of children that were on the risk register.</li> <li>• Employing staff without carrying out recruitment checks in accordance with regulations.</li> <li>• Not maintaining staff vaccination in line with current Public Health England (PHE) guidance.</li> <li>• Management of some environmental risk assessments such as fire and legionella.</li> <li>• Management of the prescribing of some high-risk medicines.</li> <li>• Management of safety alerts.</li> </ul> <p>We found that some processes to manage current and future performance were not sufficiently effective. Improvements to care and treatment were required with regard to some patient reviews, as well as subsequent follow-up activities. For example, reviews of patients who may be pre-diabetic or diabetic, the management of patients who were prescribed the medicine thyroxine and review of patients with asthma who had been prescribed recent courses of steroids.</p> <p>There were two non-medical prescribers working at the practice. One was employed by the PCN. Although both told us that they had access to informal help and advice at all times, we did not find any recorded evidence of formal supervision or audits of their prescribing.</p> <p>Following our remote searches of the practices clinical records they contacted the clinical commissioning group (CCG) medicines optimisation team the next day to seek support in response to the findings. The practice sent us an action plan on 15 May 2022 which outlined the actions they planned to take. At our on-site inspection on 17 May 2022, we saw that issues identified during the remote searches were being followed up. For example, we saw that where hospital blood test results were not previously available when monitoring patients on high risk medicines, the hospital was being contacted by the practice's in-house pharmacy team and the practice were being sent the required results.</p>	

The practice had begun to develop a written process for the recall of patients prescribed high risk drugs.

Following our inspection, we were sent evidence that the practice had provided staff with training on sepsis, stroke and myocardial infarct as part of a training afternoon. We were also sent a copy of the training slides, certificates that were issued and staff feedback.

The practice had considered service development and changes with their PCN partners and decisions were based on the data from the quality outcome framework (QOF), for example whilst making decisions on future recruitment decisions.

Four documents containing quality improvement projects and audits were sent to us prior to the inspection. One was a two cycle audit that showed improved outcomes in the second audit. The other three suggested actions including second audit cycles for two of them. We did not see any records to evidence that discussions or actions relating to the recommendations took place.

We saw that the practice had carried out a series of risk assessments. However, the fire risk assessment and the legionella risk assessment had not been carried out by staff specifically trained to do so. There were no actions identified in the fire risk assessment. The legionella risk assessment had identified that regular water temperature monitoring should be carried out monthly. Intermittent monitoring was carried out in 2017 and again in 2019. The last monitoring undertaken in September 2019 had identified that some water temperatures were outside the recommended range, but no action was taken.

The practice had previously dealt with a temporary failure of the practice computer clinical records system. Staff told us that the practice dealt well with the issue and following the event the practice now ran off hard copies of all the patient appointments the night before.

**The practice had systems in place to continue to deliver services, respond to risk and meet patients’ needs during the pandemic**

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y



Explanation of any answers and additional evidence:

The practice told us how they had adjusted how it delivered services to meet the needs of patients during the COVID-19 pandemic.

We were told that all vulnerable patients were identified by the practice through age (over the age of 70), organ transplants, active cancer treatments, immunotherapy, chronic diseases (particularly cardiac failure / respiratory) and congenital disorders such as Sickle Cell Disease.

The practice told us that during COVID, the whole staff team agreed that when dealing with patients they would be supportive in times of stress and always professional and compassionate.

They also implemented all guidelines in respect of infection prevention and control.

Staff were split in to two teams who worked on-site in the practice on alternate weeks, so that should members of one team contract COVID, the other could still continue to run the service. They were provided with personal protective equipment and lateral flow tests. All staff members that we spoke to felt that the COVID arrangements worked well and kept them safe.

Staff showed us that the list of patients requiring Long Term Condition (LTC) reviews was reviewed monthly. They send out further recalls to those not responding.

## Appropriate and accurate information

### The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	Partial
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Work was done to gather data to monitor and improve performance but it was not clear whether the information gathered was used to monitor and improve performance. For example, there was an audit carried out in 2020 looking at the management of Vitamin D replacement therapy in patients who would benefit from it. One of the recommendations was that the audit be repeated in three to six months time. There was no evidence that a follow up audit had been undertaken to demonstrate whether the recommendations were adopted and improvements made.</p> <p>The quality and outcome framework (QOF) recommenced on 01 April 2022 as one way of monitoring performance. The national GP survey which is published annually was also an indicator of performance. The practice were aware of the results of the survey and had taken action to make improvements, however, there were no records of any meetings held which reflected the decisions which were made.</p> <p>The practice clinical system was set up so that alerts were activated and clearly visible if there were recommended actions to be taken. We saw many instances where the alerts had been raised, but there was no record as to the clinical reason why they had not been addressed.</p> <p>For example, one patient was prescribed a medication that required regular blood monitoring. The last blood test recorded was 17 September 2019. The medicine was last prescribed on 23 March 2022. There was an 'overdue' alert on the notes and SMS (short message service) reminders were sent to the patient on 2 March 2022 and 5 January 2022. There was no record of a shared care protocol or link in the record. The practice was unable to download blood results from hospitals outside the local area and it was not recorded whether the blood results had been seen by the prescriber before prescribing and therefore that they could be assured it was safe to prescribe the medicine.</p> <p>One of the partners was responsible for making statutory notifications and understood what was entailed.</p>	

## Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y

Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Patient access to online services occurred through recognised third party providers which had secure access protocols and would require the input of personal security details before allowing access. The access protocols included appropriate warnings for the user.</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.	Y
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<p>Staff told us that they felt that their views were considered when making decisions. They had been kept up to date with the position with respect to potential new appointments. Staff told us that they were listened to and changes made by the practice following a request about staff pay and conditions. A relatively new member of staff had recommended a particular software package that they had used elsewhere, and it had been adopted by the practice.</p> <p>The practice had an active patient participation group (PPG) prior to the pandemic. Since the pandemic the PPG was no longer active due to a lack of availability of some key members. Practice staff told us they were now planning to reactivate the group. We were told that general patient feedback had been the primary driver around the decision to recently install a cloud based telephone system to help improve access.</p> <p>Staff told us that the introduction of more 'on the day' appointments and early morning (7am) to 2pm phlebotomy appointments were in response to patient feedback.</p> <p>The practice worked with the PCN and MDT team to build a shared view of challenges and of the needs of the population.</p>	

Feedback from Patient Participation Group.

Feedback
Currently there is not an active patient participation group

Any additional evidence

## Continuous improvement and innovation

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

	Y/N/Partial

There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence:  The practice was a training practice and had two GP registrars. The practice also encouraged staff to further develop their skills	

### Examples of continuous learning and improvement

One reception staff member had been encouraged to train as a health care assistant and had undergone health care assistant and phlebotomy training. Another clinical staff member had been encouraged to undertake a prescribers course. A third clinical staff member had been recently trained to expand their role to include injections.

## 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.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ‰ = per thousand.