

# Care Quality Commission

## Inspection Evidence Table

### The Old Dispensary (1-6621329120)

Inspection date: 07, 08 and 15 November 2022

Date of data download: 17 October 2022

## Overall rating: Inadequate

This focused inspection was undertaken to follow up on the providers action plan of improvement in accordance with the urgent conditions placed on the providers registration with CQC. As this was a focused inspection, the ratings have not been reviewed and the service therefore remains rated as inadequate overall, following our previous inspection undertaken in August 2022.

## Safe

## Rating: Inadequate

At the last inspection in August 2022 we rated the practice as inadequate for providing **safe** services because:

- Staff did not always have the information they needed to deliver safe care and treatment. Patients' needs were not always assessed, and care and treatment were not always delivered in line with current legislation. Standards and evidence-based guidance were not supported by clear pathways and tools.
- The practice did not have consistent systems for the appropriate and safe use of medicines, which included medicines optimisation.

At this inspection, we found that:

- The provider demonstrated some improvements, but new systems and processes required further embedding to ensure all patients received the appropriate reviews and treatment to meet their needs.
- Clear clinical oversight was needed to ensure all systems were fully completed and all aspects of patient review completed including medicine reviews and reviews of patients with long term conditions.

However:

- The systems for receiving documents from other services had been addressed and staff had the information they needed to support safe care and treatment.

- The systems for nursing staff to use a selection of Patient Group Directions (PGDs) to administer some previously agreed specific medicines had been updated and now followed the legal framework.
- The storage and monitoring of emergency medicines had improved and was safely managed.

## Information to deliver safe care and treatment

### Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. <sup>1</sup>	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results, and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
<ul style="list-style-type: none"> <li>• At our previous inspection in August 2022 we saw some documents that had been received electronically were not acted upon. Since our last inspection, the systems used to monitor documents received had been amended to ensure they were monitored and addressed in a timely way.</li> <li>• When the lead GP was not available, results were reviewed by the GP taking lead-responsibility that day. In the uncommon event of any test results arriving at the practice in other formats (paper or email), the communications were scanned/attached to the electronic record after review by the responsible doctor.</li> </ul>	

## Appropriate and safe use of medicines

### Medicine systems required further clinical overview to ensure they were fully completed.

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group	0.97	0.82	0.82	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)				
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). (01/07/2021 to 30/06/2022) (NHSBSA)	10.7%	8.9%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	6.71	5.44	5.31	Tending towards variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	100.9‰	102.2‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	0.41	0.58	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	4.8‰	7.2‰	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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	NA
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. <sup>1</sup>	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.	Partial
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. <sup>2</sup>	Partial

Medicines management	Y/N/Partial
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.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	NA
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	No
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<ul style="list-style-type: none"> <li>• The practice did not employ any non-medical prescribers. All prescriptions were completed by medical staff. Nursing staff used a selection of Patient Group Directions (PGDs) to administer some previously agreed, specific medicines. PGDs provide a legal framework to enable some registered health professions to supply/administer specific medicines to a pre-defined group of patients without them having to see a prescriber. At our inspection in August 2022 we saw that PGDs had not been completed correctly. This meant the use of the documents may be unlawful. The practice manager has since completed a training course to inform how the PGDs were managed and all PGDs were now updated and appropriate for use.</li> <li>• Medicine reviews were not all completed in a timely way or recorded correctly. At our previous inspection in August 2022 our searches of the practice's electronic clinical patient records system showed a lack of consistency of review. Work was undertaken to ensure all patients who needed a medicine review or a structured medicine review were identified and completed. At this inspection, our searches of the practice's electronic clinical records showed that, while significant work had been undertaken, this work had not been fully completed. Since our last inspection, 184 standard medicine reviews had been completed, however we found that 467 patients had not had a general medicines review in the last 12 months and 249 patients with long-term conditions were still outstanding appropriate monitoring and review. There was an ongoing plan to manage the remaining reviews before August 2023.</li> <li>• The practice had a policy whereby all patients prescribed 7 or more medicines received a structured medicine review (SMR). Patients with less than 7 prescribed medicines had a shorter version of a medicines review. An SMR required the input of the patient whereas a medicines review could be completed as an administrative task and without patient input. This process had been used interchangeably with some patients being seen for an SMR who had less than 7 medicines, while some patients with more than 7 medicines receiving a medicines review as an administrative task.</li> </ul>	

- Some of the medicine reviews completed since our inspection in August 2022, had gaps in them, including missing a blood pressure check for a patient on hormone replacement therapy, controlled drugs not meeting legal legislation and medicine reviews completed where the patient wasn't involved. The lack of clinical oversight meant the missing aspects of the reviews went unnoticed or unactioned. We raised this with the provider who addressed the identified shortfalls and implemented further clinical searches to try to prevent reoccurrence.
- The practice was assured the incomplete medicine reviews would be actioned as part of other reviews for long-term conditions. However, we were not assured those patients taking high risk medicines would be a priority. The systems used were not fully embedded and did not look at the risks to patients and rate the risk to promote prioritisation of review. This meant some high-risk patients may not be reviewed until 2023 or may not be identified for review at all.
- As part of our inspection, we conducted a series of clinical searches to assess the practice's procedures around medicines management and prescribing. The remote electronic review of the searches was undertaken by the CQC GP specialist advisor (SpA). Searches were carried out on the following:
- We reviewed records for patients receiving treatment for thyroid problems, who at our last inspection had not been reviewed, (the thyroid is a gland that makes and stores hormones in the body). We saw from the searches of the electronic patient records appropriate monitoring had now been completed.
- We reviewed a sample of 5 patients who required medicines for kidney disease. The dose of the medicine these patients take varies depending on their creatinine clearance level (a test to assess kidney function). This assessment requires a blood test and up to date weight measurement to calculate a score to indicate the dosage required. Four of the records reviewed showed the most recent weights or blood tests had not been used to calculate the dose needed. There was a gap of up to 3 months between the blood tests results and weight measurement being recorded and the calculation of the dose of medicine. Therefore, we could not be assured the current dose of medicine prescribed for patients was accurate.
- We reviewed patients receiving gabapentin (a group of medicines prescribed to treat epilepsy and neuropathic pain). At our last inspection we identified 4 patients who were prescribed in excess of the required dose. At this inspection we saw 1 patient had received a medicines review in August 2022 but had still received 114 extra tablets without any recorded rationale for this. We followed this up at inspection and saw significant tightening of the prescribing systems was now in place and there had not been any excessive prescribing in the last 3 months.
- At our inspection in August 2022 we saw some patients that required ongoing monitoring had not been reviewed for their health condition or the medicines they took. We saw the prescribing of SABA (Short acting Beta Antagonists) inhalers for asthma patients was not appropriately monitored. The inhalers were used by patients to improve symptoms, making it easier for patients to breathe. Searches of the patient list were run each week and patients were recalled into the practice for review. This process had identified some cases which required referral to the hospital for further respiratory review. At this inspection we saw the systems implemented to monitor this group of patients had been implemented but had not been fully effective as not all patients had been reviewed. This was because there were insufficient staff to complete all the reviews.
- At this inspection we reviewed previously identified high risk patients and saw that, with one exception, patients with incorrect Asthma Control Tests (ACT) scores had their score

Medicines management	Y/N/Partial
<p>recalculated. In some cases, this had not included an asthma review and so we were not assured the patient had received a complete review of their condition. We saw that 4 patients had not had any asthma review. The provider assured us that these patients would be recalled for review before August 2023.</p> <ul style="list-style-type: none"> <li>• Prior to our clinical searches of the practice's electronic records system undertaken as part of this inspection, there remained an inconsistent process to review patients after an exacerbation of their condition which had required treatment with steroids. Steroids were used to reduce the inflammation associated with an acute exacerbation of asthma. Since that time, the practice had implemented an audit which would identify those patients having received steroids to treat an exacerbation of their condition and would prompt the patient being recalled for review.</li> <li>• The practice data for the prescribing of Nitrofurantoin (an antibiotic medicine used to treat urinary infections) was higher than the local and England average. The provider ran searches for common antibiotic use but did not audit the outcomes. The practice did not have systems in place to monitor and audit Nitrofurantoin use and had not carried out Antimicrobial monitoring (to review the use of antibiotics) since 2020.</li> <li>• We reviewed the storage and monitoring of emergency medicines and saw it was safely managed.</li> </ul>	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. <sup>1</sup>	Yes
Staff understood how to deal with alerts.	Yes
<ul style="list-style-type: none"> <li>• Since our previous inspection in August 2022 a system had been implemented to monitor and ensure compliance with Medicines and Healthcare Products Regulation Agency (MHRA) alerts. Our remote searches of the practice's electronic clinical patient records system, showed the practice had taken action in response to minimise risks to patients. We identified that, while all patients had been contacted and some had been seen by a clinician, others had still not responded to the multiple alerts sent to them asking they contact the surgery. Clinical oversight was needed to ensure auditing was maintained and those not yet seen by the practice were followed up to attend.</li> </ul>	



## Effective

## Rating: Inadequate

At the last inspection in August 2022 we rated the practice as inadequate for providing effective services because:

- There was monitoring of the outcomes of care and treatment, but not all audits provided the assurance needed.
- Staff were not always consistent and proactive in helping patients to live healthier lives.
- The practice was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance. The practice could not show how it shared learning and made improvements when things went wrong.
- Learning from complaints was not well managed

At this inspection, we found that:

- The provider demonstrated some improvement, however, the new systems and processes required further embedding to ensure all patients received the appropriate reviews and treatment to meet their needs.
- Clear clinical oversight was needed to ensure all systems were fully implemented and all aspects of patient reviews were completed.
- There was limited monitoring of the outcomes of care and treatment. Patients' needs were not always assessed, and care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles.
- The practice was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

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

### Effective needs assessment, care and treatment

**Patients' needs were not always assessed, and care and treatment were 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.	Partial

Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. <sup>1</sup>	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. <sup>2</sup>	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated. <sup>3</sup>	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice prioritised care for their most clinically vulnerable patients.	Yes
<ul style="list-style-type: none"> <li>• The protocols needed to ensure consistent safe monitoring and practice had mostly been implemented. For example, the MHRA alerts used to direct practices to review and change some medicine combinations, had mostly been actioned. Further work was needed to complete this.</li> <li>• Some audits had been used previously to promote patient health and wellbeing, but due to the lack of clinical staff they were not currently being used and were not scheduled to restart until 2023.</li> <li>• The practice had previously monitored accident and emergency admissions for patients over 75 years, but this had stopped at the start of the pandemic and there were no immediate plans to recommence them.</li> <li>• The urgent conditions placed on the providers registration had required clinical staff to update their training relating to long term conditions and asthma control tests and how to use the electronic recording systems correctly. This training has not yet been implemented, and there were plans to look how this could be facilitated.</li> </ul>	

## Effective care for the practice population

### Findings

- The practice website and notice boards provided information, advice and signposting for a range of health promotion.
- The practice assessed and monitored the physical health of people with mental illness. Patients with poor mental health, including dementia, were referred to appropriate services. The practice took part in the Dementia Enhanced Service, screening patients for this condition and offering intervention if required. Screening could be undertaken at home by the Assistant Practitioner when patients were unable to come to the surgery. The practice was accredited by the Wessex Academic Health Science Network (AHSN) as a Dementia Friendly Practice after implementing iSPACE, an innovative model of dementia-friendly primary care. We reviewed 3 care plans for patients who had a diagnosis of dementia and found 1 had a code placed on their clinical record to indicate a review had been completed, however, we



saw no evidence of this taking place as there was no written narrative recorded in their patient records.

- All patients with a learning disability were offered an annual health check and support for vulnerable patients was maintained. The health checks were not audited and there was no clinical oversight of the support being provided. This service was provided by the practice nurse and would be considered once practice staff had capacity.
- End of life care was delivered in a coordinated way which considered the needs and requests of those whose circumstances may make them vulnerable. The practice had not audited end of life care since 2020 and so did not have assurance or oversight that the care provided was in line with guidance and current best practice. Due to a lack of staff capacity were no current plans to reimplement these audits.
- The practice had access to a social prescriber to support older patients and their carers to maintain independence and improve quality of life in the community. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The practice carried out regular cervical screening for women aged 24-65. This was also used as an opportunity to consult and assess in respect of sexual health, contraception and chlamydia testing. They also ran well-woman and well-man clinics and NHS health checks. The practice carried out six-week mother and baby checks.

## Management of people with long-term conditions

### Findings

- At our inspection in August 2022 patients with long term conditions were not always offered a structured annual review to monitor and review their health and medicines needs. We provided a list of patients we had identified from our remote searches who required review and we required this review work to be urgently completed. We saw not all reviews had been completed and not all patients had been invited for appropriate assessments with appropriate intervention and management. The process implemented was not consistently followed with some patients having received an appropriate review whilst other clinical records showed a review had been completed but some of those patients had not been included in those reviews, when they should have been.
- The practice maintained registers of patients with long-term conditions such as diabetes, asthma, vascular/heart disease, hypertension, thyroid disease, cancer, rheumatoid arthritis and stroke. The system was also planned to incorporate those patients who had not yet attended for a regular review within the appropriate timeframe. to ensure they were invited for relevant monitoring and review appointments. The registers were used to highlight which of the patients were a priority for review. The newly implemented system was not fully embedded and so we found some patients who should have been invited had not been included. This meant that some patients remained at risk of not being seen in a timely way. The practice lacked the clinical oversight to ensure that the newly implemented systems were effective.

## Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	No
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.	Partial

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

- The practice had not participated in any national and local quality improvement initiatives. The practice lead told us that the Primary Care Network (PCN) would undertake the initiatives and if appropriate would include the practice.
- The practice is a member of the Wimborne and Ferndown Primary Care Network (PCN). The group met monthly to discuss administrative, clinical and planning issues (the lead GP and practice manager attended). In addition, the practice managers met regularly to support practice management issues. The PCN were available to support the practice in the work identified at the previous inspection.
- The practice were also members of Castleman GP Federation which involves a larger group of GPs from North Poole and the Wimborne, Ferndown and Crane Valley areas. This group supports the work of the PCNs administratively and clinically.
- The practice had previously conducted a range of clinical audits to review and monitor activity at the practice, but during the current period of special measures audits had not been undertaken. Audits were used to reflect on the changing health needs of the local population and the lack of audits including frailty, mortality and admissions and referrals to hospital meant the service could not identify if they were meeting the needs of the population.

## Effective staffing

### The practice was unable 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.	Partial
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	No
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes

The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	No
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<ul style="list-style-type: none"> <li>• Clinicians, for example GPs and nursing staff, were required to maintain their professional registration and demonstrate their competencies when they revalidated with the relevant professional body. The practice monitored their up to date registrations to ensure they were registered to practice.</li> <li>• The urgent conditions placed on the provider's registration required clinical oversight must be introduced for all medical and non-medical clinicians to ensure they have the necessary knowledge, skills and competence to ensure delivery of safe care and treatment to service users. The training was to include long-term conditions clinical training and training to ensure correct use and understanding of the clinical records system and clinical assessment tools, including accurate coding, action following receipt of secondary care correspondence, and Asthma Control Test assessment tool.</li> <li>• At this inspection we saw that clinical training in long-term conditions was planned but had still not been implemented and training for the use of the electronic recording systems had not been provided. However, staff were aware of how to manage secondary care correspondence.</li> <li>• During the August 2022 inspection, we identified the ACT scores for asthma patients were not being calculated correctly which meant we were not assured patients were being provided with the right level of care, support and treatment. At this inspection we saw the ACT scores had been recalculated and some actions completed. Not all patients had been reviewed and some actions remained outstanding. We were not aware that staff had received any training in the calculation of the ACT scoring system.</li> <li>• Since the last inspection the management staff had been required to undertake electronic searches to identify patients who were overdue appropriate monitoring and review of their long-term conditions and prescribed medicines. They had not been allocated time to complete any training to support them with this change of role.</li> <li>• Following our inspection in August 2022, the practice manager had completed training to manage the Patient Group Directions (PGDs) and records reflected the training provided.</li> </ul>	

## Helping patients to live healthier lives

### Staff were not consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Partial

Staff discussed changes to care or treatment with patients and their carers as necessary.	Partial
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
<ul style="list-style-type: none"> <li>The systems used to monitor and record health checks did not ensure all patients were contacted or seen by a GP for ongoing review. We saw as part of our remote electronic searches at this inspection and the previous inspection that some monitoring of long term conditions and high-risk medicines were not consistently reviewed and managed. The records seen did not demonstrate that patients had been involved in their monitoring and or supported in managing their own health.</li> <li>The practice had used a PCN Social Prescriber to work with patients, particularly patients who were registered as carers.</li> <li>Information was available on the practice website regarding action and support to live healthier lives. Information regarding health and wellbeing was also provided to patients during health checks and appointments with clinicians.</li> </ul>	

### Consent to care and treatment

**The practice was unable to demonstrate that it 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.	Partial
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	No
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. <sup>1</sup>	Partial
<ul style="list-style-type: none"> <li>The GPs used opportunities as they presented, to ensure Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders were reviewed and updated. Those agreements of care ensured the correct legal pathways were followed to support patient choice. However, we reviewed 3 patients records and saw that whilst 2 were completed appropriately, 1 DNACPR was not. This patient had 2 DNAR CPR decisions in their patient record, 1 stated the patient had capacity and the other stated they did not have capacity. Both were completed on the same day. The patient's notes stated they lacked capacity to consent to the decision being made about their treatment. Capacity is decision and time specific. If a GP has a reason to doubt the capacity of a patient, they should complete a Mental Capacity Act assessment with the patient and record a best interest decision, to ensure that any decisions made about whether to resuscitate the patient or not, were made in their best interest. This process had been completed by telephone and had not included the patient at any point.</li> </ul>	

## Well-led

## Rating: Inadequate

At the last inspection in August 2022 we rated the practice as inadequate for providing **well-led** services because:

- Leaders could not consistently demonstrate they had the capacity and skills to deliver high quality sustainable care. The practice had a clear vision, but it was not supported by a credible strategy to provide high quality sustainable care. Aspects of the practice culture supported sustainable care.
- The overall governance arrangements were ineffective, and the practice did not have clear and effective processes for managing risks, issues and performance.

At this inspection, we found that:

- The provider demonstrated some improvements, but the new systems and processes required further embedding to ensure all patients received the appropriate reviews and treatment to meet their needs.
- Leaders could not demonstrate they had the capacity and skills to deliver high quality sustainable care.
- The overall governance arrangements required more clinical oversight and support to ensure they developed to be effective.
- The practice did not have embedded and effective processes for managing risks, issues and performance.

However:

- The practice had a clear vision and credible strategy to provide high quality sustainable care.
- The practice had a culture which drove high quality sustainable care.
- The practice involved the public, staff and external partners to sustain high quality and sustainable care.
- There was evidence of systems and processes for learning, continuous improvement and innovation.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	No

- Following our inspection in August 2022, we placed urgent conditions on the providers registration which directed the provider to ensure all appropriate monitoring and review of patients was completed by 1 November 2022. At this inspection we saw that the practice undertaken a lot of work to meet those conditions and had worked with stakeholders, commissioners and the local primary care network (PCN) to increase staff resource capacity and complete their action plan. At this inspection undertaken we found the provider had not fully met all of the urgent conditions placed on their registration. Following this inspection we asked the provider for an updated action plan setting out appropriate timeframes when a backlog of work regarding the monitoring and review of all relevant patients would be completed. The action plan submitted to us did not provide us with assurances the provider had the capacity to ensure care and treatment of patients was delivered in a timely way.
- During the previous 3months, the service had reduced staffing capacity. The urgent conditions imposed on the provider's registration, meant staff had worked longer hours and undertaken a wider scope of role than they were used to. Staff had been flexible in how they worked to meet the increased demands placed upon them. There had been a reduced level of clinical oversight which had placed an extra burden on them,
- Partners held managerial and financial responsibility for running the practice. There was a business development plan for the ongoing running and development of the service.
- The clinical overview of the service did not demonstrate a clear understanding of what was required to manage challenges to quality and safety. At our previous inspection, we identified patients had not always received the correct and appropriate care. Arrangements for identifying, managing and mitigating risks had been implemented but were in their infancy and were not consistently effective. This demonstrated a lack of clinical oversight and the potential risk to the patients and the practice.
- Staff spoke positively about the support they had from colleagues and told us they could speak to GPs or the practice manager for support when necessary.
- We saw no evidence of a succession plan.

## 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.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
<ul style="list-style-type: none"> <li>• The ongoing practice development was reviewed as part of operational meetings with clinical and practice staff. The practice manager spoke with staff about the vision for the service and the day to day strategy to achieve their goals.</li> <li>• Staff were aware of the vision of the practice and felt involved directly in its development. The current development of the practice to meet the urgent conditions placed on the provider's</li> </ul>	



registration, had been embraced by staff and they spoke about their input and involvement in the practice and how they supported the management of changes to meet patient's needs.

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behavior inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Partial
There were systems to ensure compliance with the requirements of the duty of candor.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
<ul style="list-style-type: none"> <li>• Staff we spoke with both before and during the inspection told us the practice had some systems to support the well-being and welfare of staff. The practice staff had been fundamental in supporting the service provision since the last inspection. The work undertaken since the last inspection had been largely organised and undertaken by the administrative staff. They had little training or support with this and had managed the changes well. Staff told us they had not always received day to day support and had relied on each other for support and maintenance of their well-being.</li> <li>• The practice could access a Freedom to Speak Up Guardian. Staff described how they could safely raise concerns and what action was taken.</li> <li>• Staff spoke clearly about their responsibility under their Duty of Candour.</li> </ul>	

## Governance arrangements

### The overall governance arrangements required more clinical oversight and support to ensure they developed to be effective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
<ul style="list-style-type: none"> <li>• During the previous inspection in August 2022, we identified shortfalls within the governance arrangements. This was with reference to regular monitoring and to ensure appropriate oversight of the quality and safety of the provision of the service.</li> <li>• The practice had implemented a program of audits to monitor the quality of the service, to identify shortfalls and to make improvements. We saw an overview was maintained for the</li> </ul>	

administrative staff of safety alerts, health checks and monitoring of long-term conditions, medicines prescribing, monitoring of high-risk medicines, monitoring controlled medicines, antimicrobial monitoring or the management of emergency medicines. There were also audits or overviews of document downloads, and patient group directions. We saw the clinical oversight did not ensure that, once the patients who were overdue reviews were identified and invited to appointments, all the required actions for each of those patients were fully completed.

- Clinical meetings were now held routinely, and audits and governance were discussed. Staff meetings were held every month and minutes and a practice log were maintained to record all ongoing issues.
- Complaint and incident outcomes were reviewed by practice staff to ensure learning and full compliance with any actions. There had been one complaint received since our last inspection and we saw it had been investigated and learning shared.
- Audits of the services provided had not been recommenced as a result of other priorities to meet the urgent conditions.

## Managing risks, issues and performance

**The practice did not have embedded and effective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<ul style="list-style-type: none"> <li>Risk assessments were not used to monitor and mitigate against all identified risks. Some areas of the practice, new changes were not risk managed consistently. For example, systems for managing risks were not fully embedded to ensure all patients were appropriately prioritised for asthma review.</li> <li>There were ineffective arrangements for identifying and managing risks. The monitoring system used by the practice to provide them with clinical assurance was a series of audits completed throughout the year and using registers to identify when patients needed to be seen and monitored. The audits used had not been undertaken and there was no evidence in patients records of the appropriate monitoring and risk assessment having taken place.</li> </ul>	

## Appropriate and accurate information

**There was a demonstrated commitment to using data and information proactively to drive and support decision making.**

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
<ul style="list-style-type: none"> <li>Patients who did not attend appointments were monitored to ensure follow up contact was made, and appointments rebooked. Systems had been implemented which involved a series of searches of the electronic system each week to identify patients who needed to be called for review. However, action regarding the follow up of those patients weren't implemented until after our site visit and the potential risks had not been considered</li> <li>Staff meetings now included reference to staff performance and areas for improvement.</li> </ul>	

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

**The practice involved the public, staff and external partners to sustain high quality and sustainable care.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	No
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<ul style="list-style-type: none"><li>• The practice gathered information from a suggestions box, a suggestions platform available on the practice website and face to face feedback. We saw positive and supportive emails, cards and letters which had been sent by patients and their families. They were shared with the staff to ensure that any learning and support was available to all staff.</li><li>• The practice had a 'You said.... We did' board which enables comments from patients to be actioned. The last comments and actions noted from October 2022 and no further updates had been included.</li><li>• The practice told us that NHS 'friends and family' surveys were used as feedback. Feedback was assessed and learning implemented when required to improve service quality. There was no auditable record of how learning and changes were implemented.</li></ul>	

## Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"><li>• The Patient Participation Group (PPG) and the PPG survey has not been recommenced since our last inspection. The practice told us they previously ran a virtual PPG and had nearly 600 members. The PPG did not have a chairperson as the practice preferred to encourage patients to express their views</li></ul>

## 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.	Yes
<ul style="list-style-type: none"> <li>Since our previous inspection in August 2022 significant work had been undertaken to develop the service and ensure patients were appropriately reviewed and managed. The staff had developed new systems to ensure that patients were now risk assessed and prioritised for review. This was an ongoing process of development and staff told us they were committed to the learning process.</li> </ul>	



## 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 SICBL 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 SICBL 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.